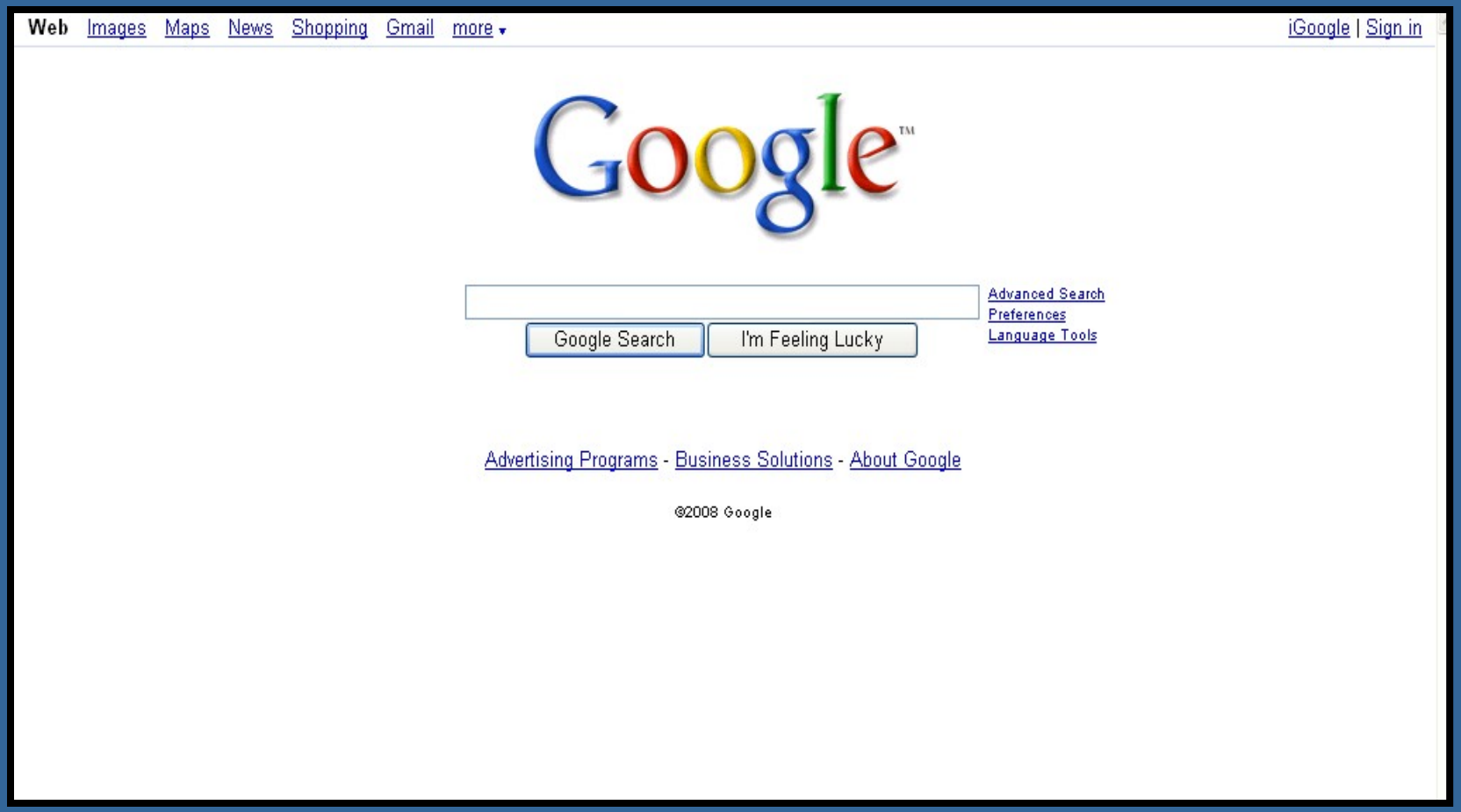
How to Use the Resources of the Telelibrary Project Effectively

Jane A. Pellegrino, MSLS, AHIP
Department Head, Library Services
Naval Medical Center Portsmouth

Why do health professional look for clinical information?

- To stay current with new relevant medical developments
- To find answers to patient-specific clinical questions

When you need information, where do YOU start?



Where does Google Fit In?

Google **http://www.google.com**

- Great locating tool for specific information
- Rarely scholarly, not a substitute for library reference databases
- Unstable

Google Scholar **http://scholar.google.com**

- Searches peer-reviewed papers, books, theses, etc.
- Leads to fee-based online full-text websites

Objectives

- Look beyond Google
- Formulate a clinical question
- Select appropriate resources to answer a clinical question
- Search PubMed or CINAHL to find the answer to a clinical question
- Find online full-text available through the Telelibrary

Clinical Questions

- What patients are at greatest risk for RSV infections?
- What are the current guidelines for treating acute otitis media?
- Does clonidine pose a risk to the fetus in a hypertensive patient?
- What are the diagnostic criteria for Lyme disease?
- Should healthy patients over 65 years of age receive pneumococcal vaccine and does immunization reduce hospitalization for

Where do I begin?

- **Formulate the question**
  - Identify key concepts
  - PICO (patient, intervention, comparison, outcome)

- **Choose a likely source of the information**
  - Is it an overview of a subject found in a textbook or other full-text reference?
  - Is it a set of specific drug facts?
  - Is there a guideline on the clinical question?
  - Is it the latest journal article?

Formulate a good, answerable clinical question

Identify key concepts

Question	Concepts
What patients are at greatest risk for RSV infections?	RSV, repiratory syncytial virus, risk
What are the current guidelines for treating acute otitis media?	otitis media, acute illness, therapy, drug therapy, guidelines
Does clonidine pose a risk to the fetus in a hypertensive patient?	clonidine, pregnancy complications, fetal, hypertension therapy

Choosing the right tool

- **To stay current with new relevant medical developments**
  - American Family Physician, Journal of Family Practice, JAMA, New England Journal of Medicine
  - MD Consult
  - Stat!Ref
    - ACP Medicine, ACS Surgery
  - eMedicine (CME)
  - Journals in online full-text
-

Choosing the right tool

- **To find answers to patient-specific clinical questions**
  - UpToDate
  - MD Consult
  - eMedicine
  - eBooks
    - Stat!Ref - ACP Medicine, ACS Surgery
    - Books @ Ovid
  - Practice Guidelines and Systematic Reviews

Telelibrary Reference Links

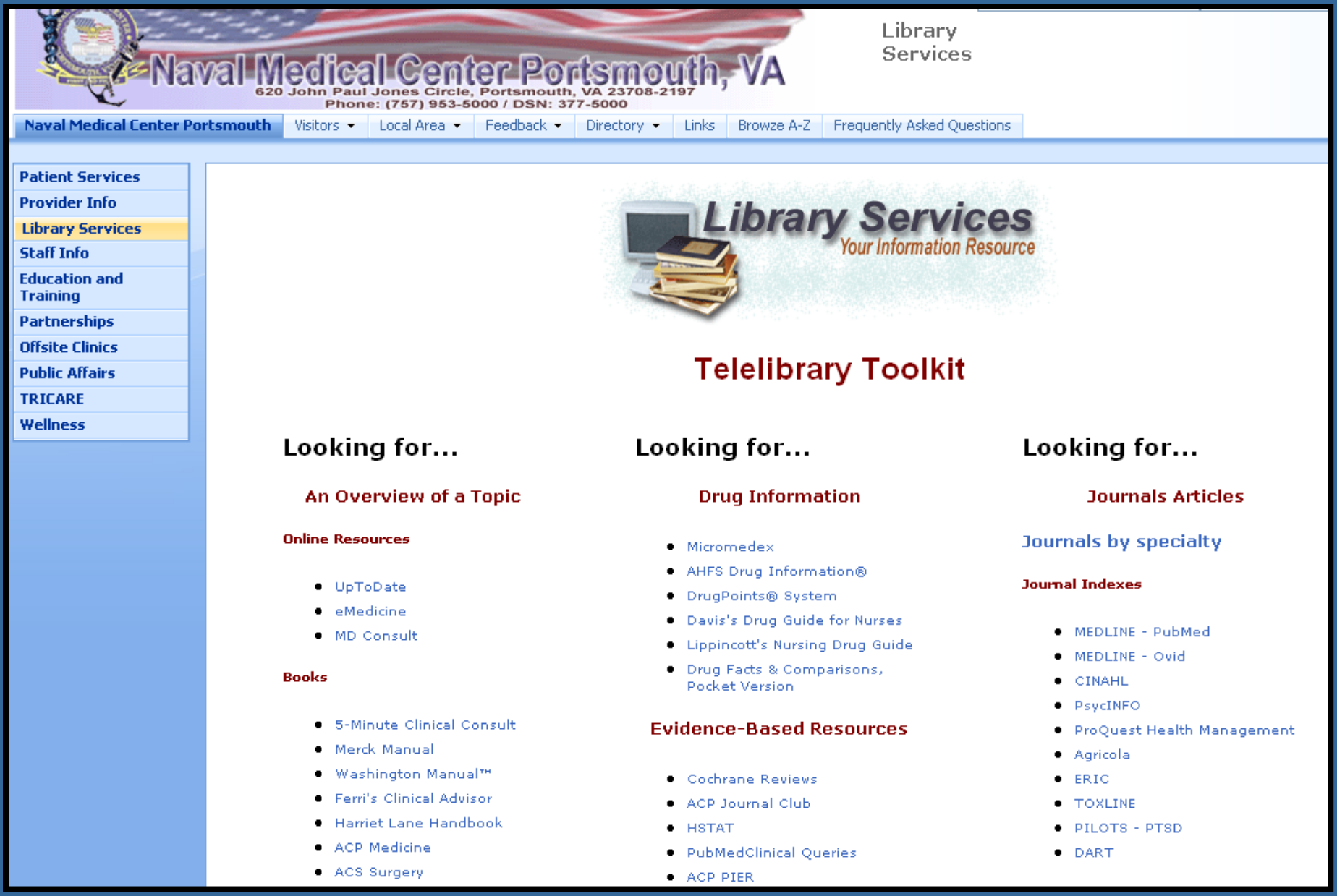
- SilverPlatter Databases (ERL Server).
- Ovid Online. **NOTE: For quick links to individual Ovid journals, textbooks, etc., go to the following page:** jumpstart.htm.
- MD Consult.
- Micromedex.
- EMedicine Clinical Knowledge Base. **NOTE: For instructions on accessing free CME, go to the following document:** EMED_CME.PDF.
- JCAHO Comprehensive Accreditation Manual for Ambulatory Care (CAMAC), 2008 Core Manual.
- JCAHO Comprehensive Accreditation Manual for Hospitals (CAMH), 2008 Core Manual.
- New England Journal of Medicine. **NOTE: This journal can also be accessed by logging on to Navy Medicine Online (NMO). The link to the journal is under the Tools tab.**
- StatRef Complete Medical Reference.
  - Listing of StatRef Textbooks by Subject Area.
- Health and Wellness Resource Center.
- ProQuest Health Management.
  - MyILibrary Health Management Text Books.
- Up-To-Date.
- BUPERS.
- Medical Environmental Disease Intelligence and Countermeasures (MEDIC).
- NIOSH Databases.
- The Centers for Medicare & Medicaid Services (CMS) Disc 1.
- The Centers for Medicare & Medicaid Services (CMS) Disc 2.
- Medical Disability Advisor.
- **AMA Graduate Medical Education (GME):**
  - AMA Graduate Medical Education Library 2008-2009.
  - AMA Graduate Medical Education Directory for prior years.
- **Borden Compendium:**
  - Medical Consequences of Nuclear Warfare.
  - Anesthesia and Perioperative Care of the Combat Casualty.
  - Medical Aspects of Chemical and Biological Warfare.
  - Medical Aspects of Harsh Environments Volume 1.
  - Medical Aspects of Harsh Environments Volume 2.
  - Military Medical Ethics Volumes 1 and 2.
  - Military Preventive Medicine Volume 1.
  - Military Psychiatry.
  - Occupational Health.

https://tlib.med.navy.mil

CAC required

Links are also available at Navy Medicine Online

https://nmo.med.navy.mil



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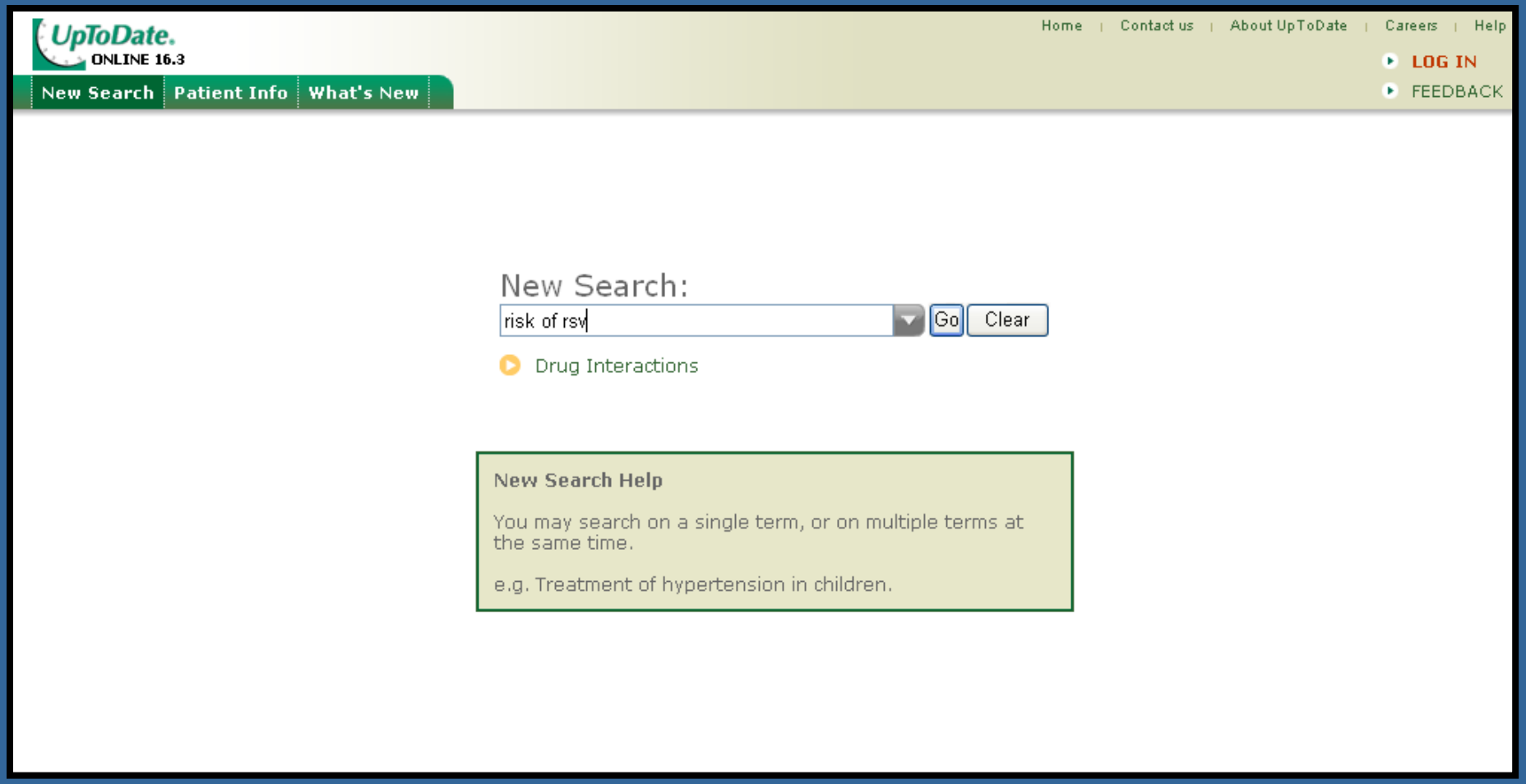
Question #1 –
Brief Clinically Related Question
Try UpToDate

What patients are at greatest risk for RSV infections?

UpToDate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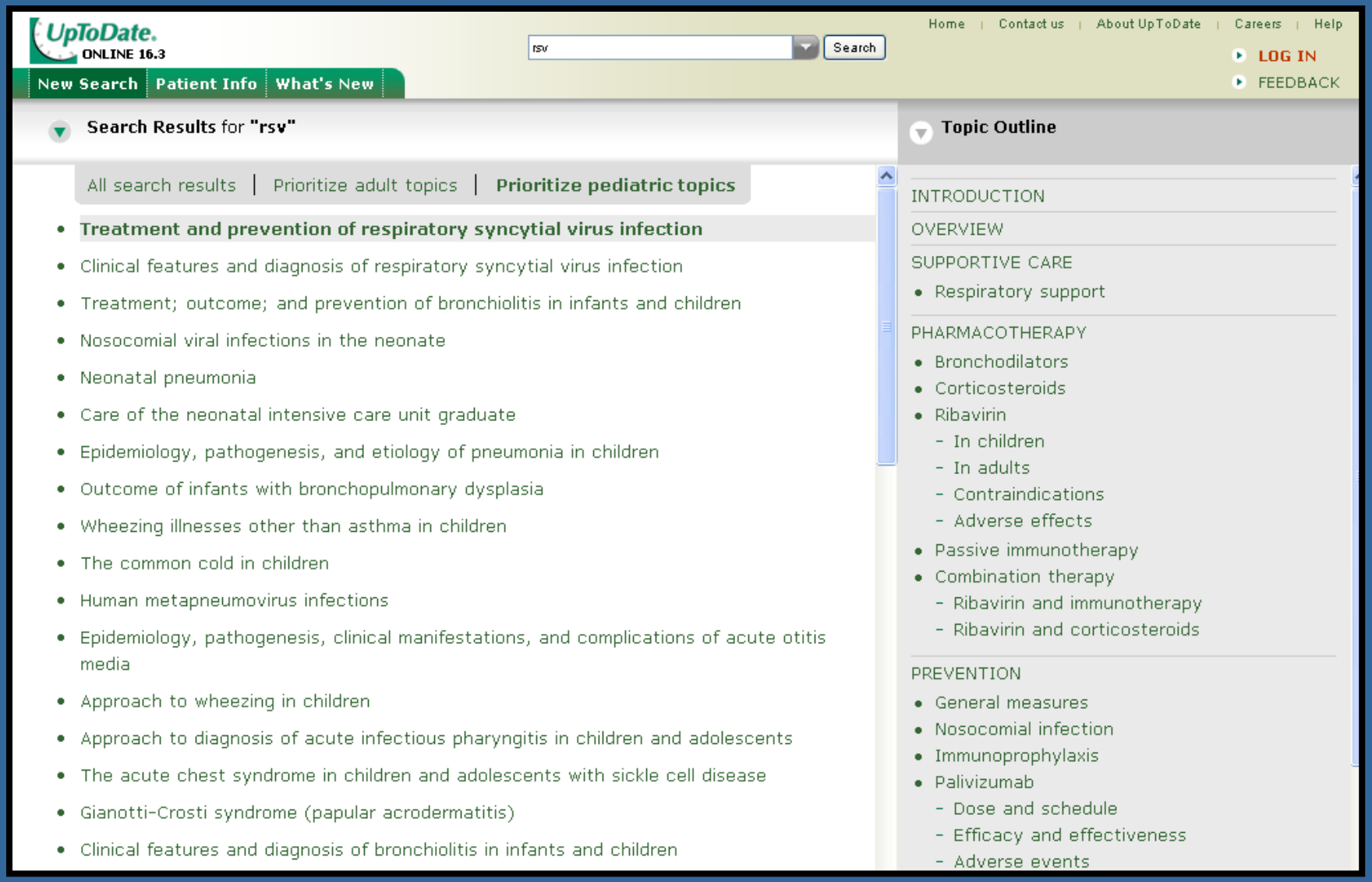
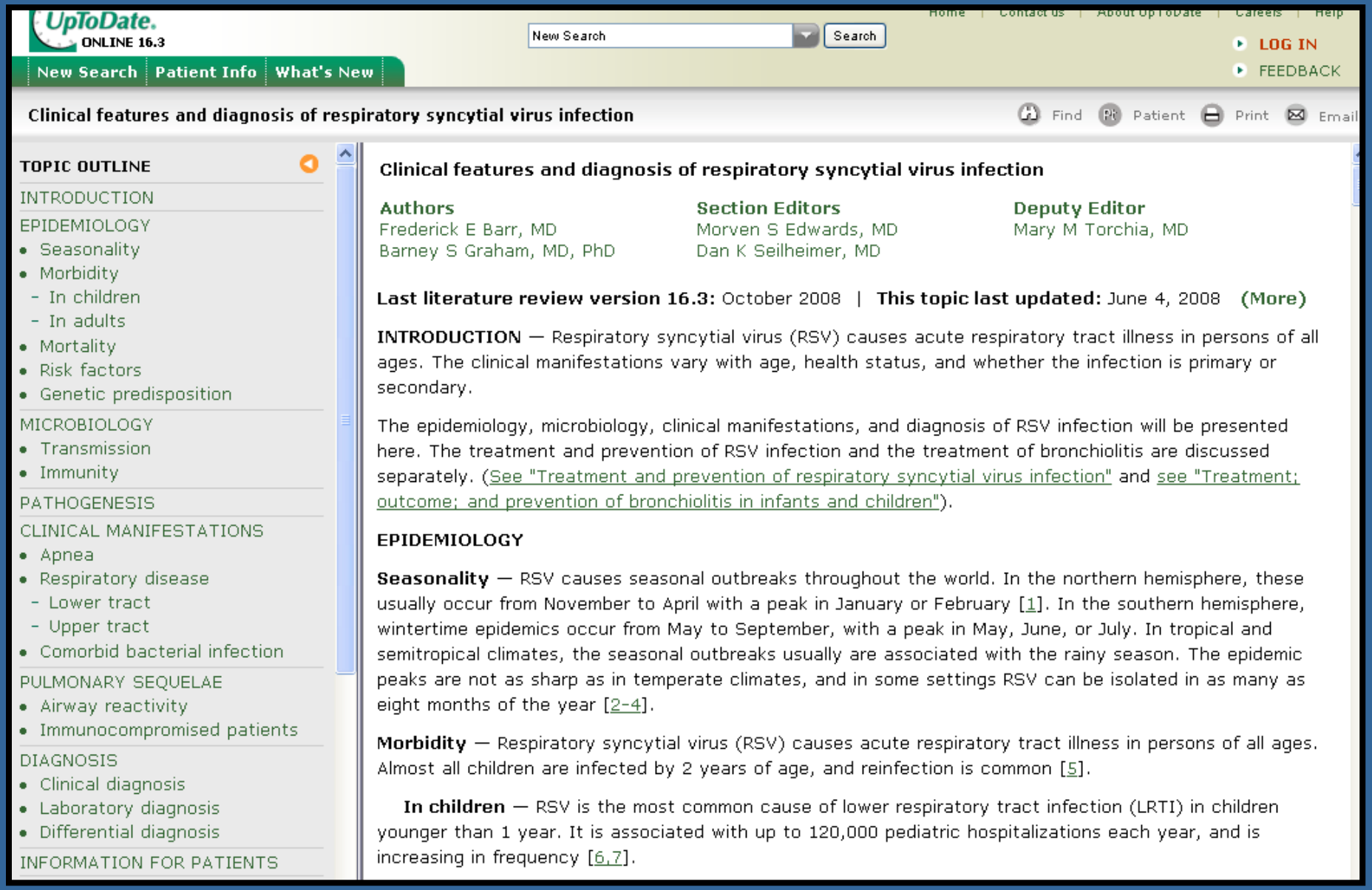
You may search on a single term, or on multiple terms at the same time.
e.g. Treatment of hypertension in children.

RSV - UpToDate



Risk of RSV - UpToDate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Clinical features and diagnosis of respiratory syncytial virus infection
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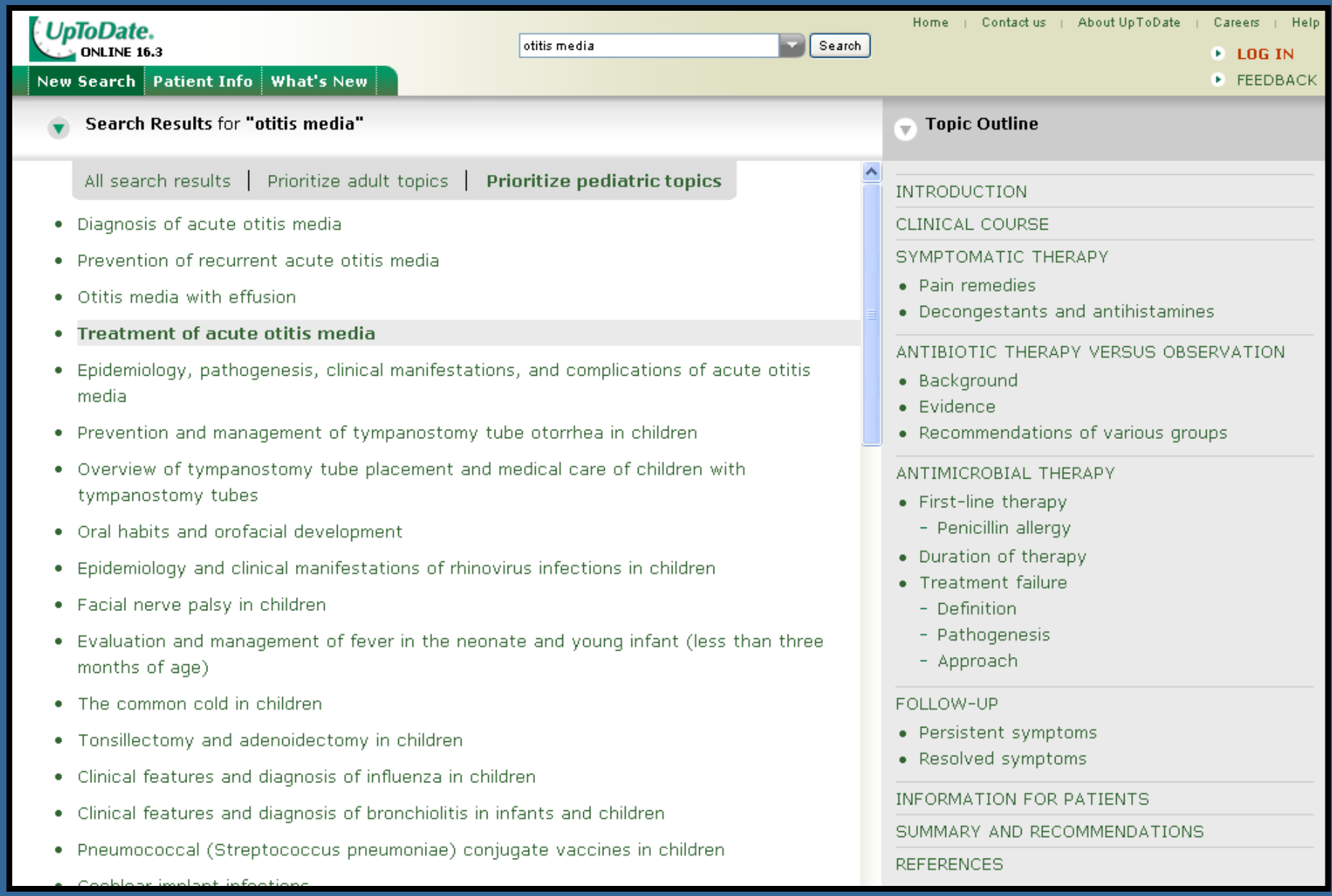
• Respiratory disease
- Lower tract
- Upper tract
• Comorbid bacterial infection
PULMONARY SEQUELAE
• Airway reactivity
• Immunocompromised patients
DIAGNOSIS
• Clinical diagnosis
• Laboratory diagnosis
• Differential diagnosis
INFORMATION FOR PATIENTS
Clinical features and diagnosis of respiratory syncytial virus infection
Authors
Frederick E Barr, MD
Barney S Graham, MD, PhD
Section Editors
Morven S Edwards, MD
Dan K Seilheimer, MD
Deputy Editor
Mary M Torchia, MD
Last literature review version 16.3: October 2008 | This topic last updated: June 4, 2008 (More)
INTRODUCTION — Respiratory syncytial virus (RSV) causes acute respiratory tract illness in persons of all ages. The clinical manifestations vary with age, health status, and whether the infection is primary or secondary.
The epidemiology, microbiology, clinical manifestations, and diagnosis of RSV infection will be presented here. The treatment and prevention of RSV infection and the treatment of bronchiolitis are discussed separately. (See "Treatment and prevention of respiratory syncytial virus infection" and see "Treatment; outcome; and prevention of bronchiolitis in infants and children").
EPIDEMIOLOGY
Seasonality — RSV causes seasonal outbreaks throughout the world. In the northern hemisphere, these usually occur from November to April with a peak in January or February [1]. In the southern hemisphere, wintertime epidemics occur from May to September, with a peak in May, June, or July. In tropical and semitropical climates, the seasonal outbreaks usually are associated with the rainy season. The epidemic peaks are not as sharp as in temperate climates, and in some settings RSV can be isolated in as many as eight months of the year [2-4].
Morbidity — Respiratory syncytial virus (RSV) causes acute respiratory tract illness in persons of all ages. Almost all children are infected by 2 years of age, and reinfection is common [5].
In children — RSV is the most common cause of lower respiratory tract infection (LRTI) in children younger than 1 year. It is associated with up to 120,000 pediatric hospitalizations each year, and is increasing in frequency [6,7].

Question #2 – Discussion of Current Management

Try **UpToDate**

What are the current guidelines for treating acute otitis media?

UpToDate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All search results | Prioritize adult topics | Prioritize pediatric topics
Diagnosis of acute otitis media
Prevention of recurrent acute otitis media
Otitis media with effusion
Treatment of acute otitis media
Epidemiology, pathogenesis, clinical manifestations, and complications of acute otitis media
Prevention and management of tympanostomy tube otorrhea in children
Overview of tympanostomy tube placement and medical care of children with tympanostomy tubes
Oral habits and orofacial development
Epidemiology and clinical manifestations of rhinovirus infections in children
Facial nerve palsy in children
Evaluation and management of fever in the neonate and young infant (less than three months of age)
The common cold in children
Tonsillectomy and adenoidectomy in children
Clinical features and diagnosis of influenza in children
Clinical features and diagnosis of bronchiolitis in infants and children
Pneumococcal (Streptococcus pneumoniae) conjugate vaccines in children
Cochlear implant infections
Topic Outline
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Pain remedies
Decongestants and antihistamines
ANTIBIOTIC THERAPY VERSUS OBSERVATION
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ANTIMICROBIAL THERAPY
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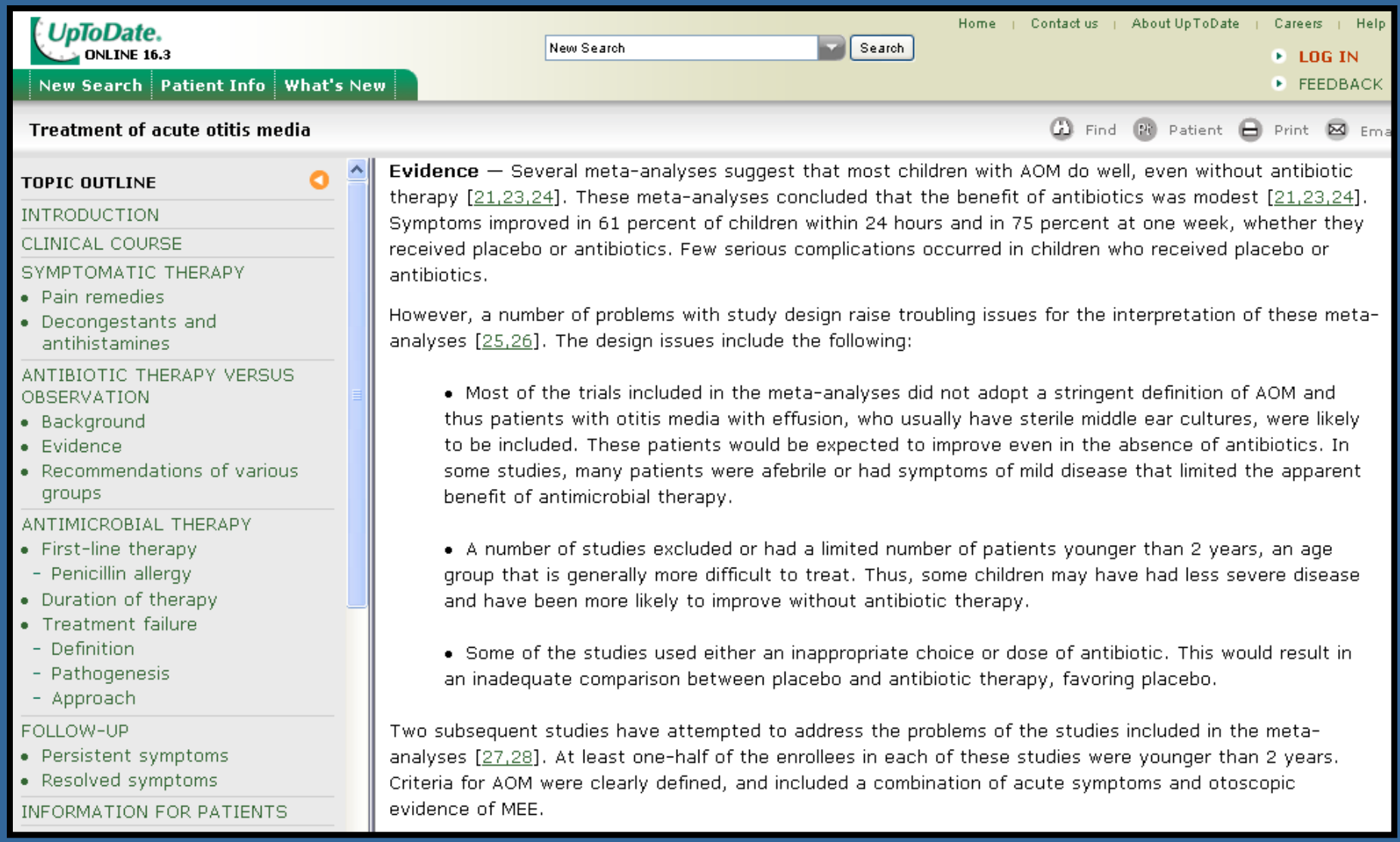
Penicillin allergy
Duration of therapy
Treatment failure
Definition
Pathogenesis
Approach
FOLLOW-UP
Persistent symptoms
Resolved symptoms
INFORMATION FOR PATIENTS
SUMMARY AND RECOMMENDATIONS
REFERENCES

Acute Otitis Media - UpToDate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ANTIMICROBIAL THERAPY
• First-line therapy
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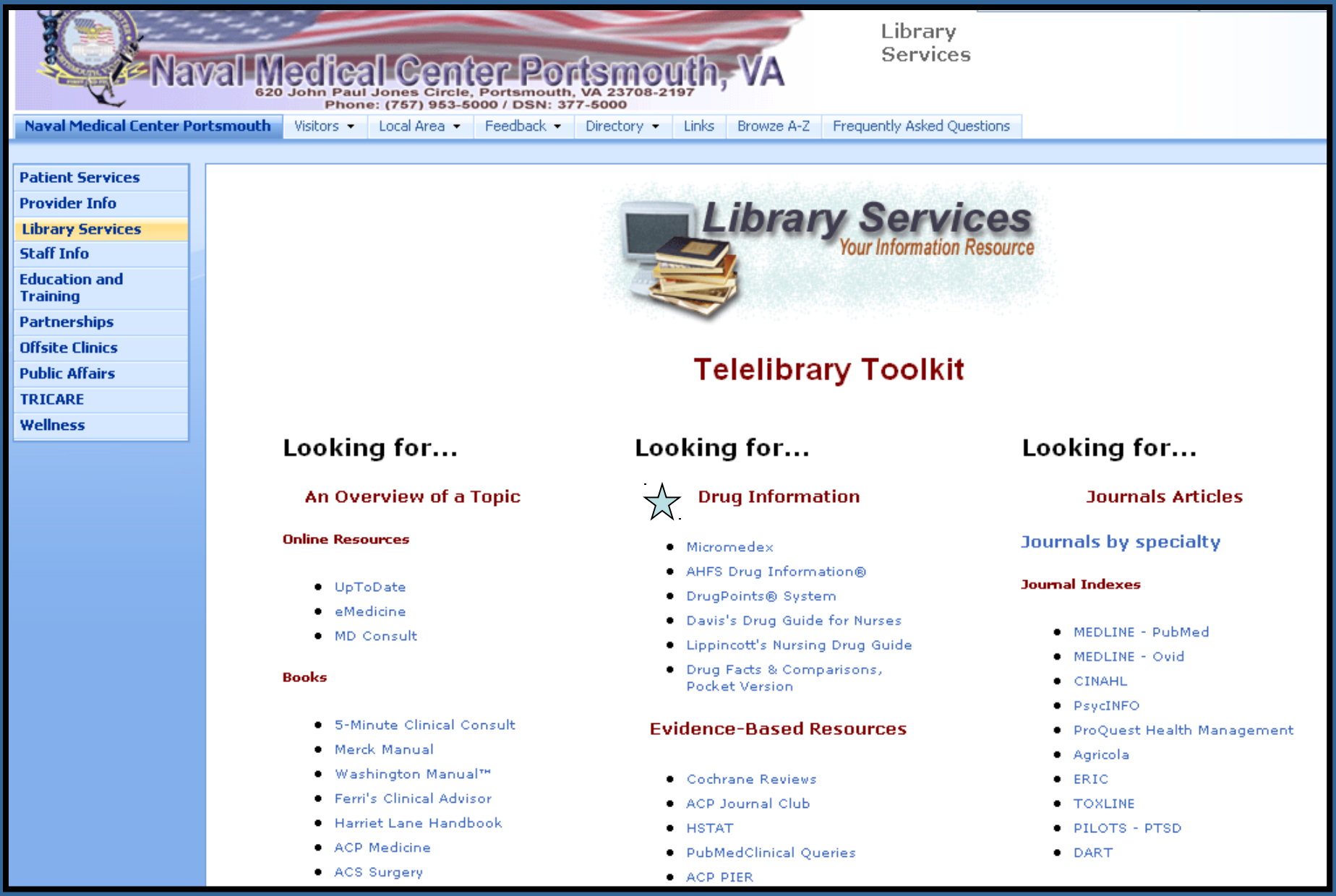
• Duration of therapy
• Treatment failure
– Definition
– Pathogenesis
– Approach
FOLLOW-UP
• Persistent symptoms
• Resolved symptoms
INFORMATION FOR PATIENTS
Evidence — Several meta-analyses suggest that most children with AOM do well, even without antibiotic therapy [21,23,24]. These meta-analyses concluded that the benefit of antibiotics was modest [21,23,24]. Symptoms improved in 61 percent of children within 24 hours and in 75 percent at one week, whether they received placebo or antibiotics. Few serious complications occurred in children who received placebo or antibiotics.
However, a number of problems with study design raise troubling issues for the interpretation of these meta-analyses [25,26]. The design issues include the following:
• Most of the trials included in the meta-analyses did not adopt a stringent definition of AOM and thus patients with otitis media with effusion, who usually have sterile middle ear cultures, were likely to be included. These patients would be expected to improve even in the absence of antibiotics. In some studies, many patients were afebrile or had symptoms of mild disease that limited the apparent benefit of antimicrobial therapy.
• A number of studies excluded or had a limited number of patients younger than 2 years, an age group that is generally more difficult to treat. Thus, some children may have had less severe disease and have been more likely to improve without antibiotic therapy.
• Some of the studies used either an inappropriate choice or dose of antibiotic. This would result in an inadequate comparison between placebo and antibiotic therapy, favoring placebo.
Two subsequent studies have attempted to address the problems of the studies included in the meta-analyses [27,28]. At least one-half of the enrollees in each of these studies were younger than 2 years. Criteria for AOM were clearly defined, and included a combination of acute symptoms and otoscopic evidence of MEE.

Question #3 –
Question on the Safety of a Drug
Try **MicroMedex**

Does clonidine being taken by a hypertensive mother pose a risk to the fetus?



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Choose MicroMedex

MicroMedex

Terms Matched{CLONIDINE; }

- **Summary Documents**
  - Drug Summary Information [2 Related Occurrences]
  - Toxicologic Management Summary [CLONIDINE - Toxicologic Management Summary]
- **Drug Information**
  - DRUGDEX DRUG EVALUATIONS [108 Related Occurrences]
  - Ingredients from DRUGDEX Tradename Products [2 Related Occurrences]
  - DRUG CONSULTS [9 Related Occurrences]
  - MARTINDALE - The Complete Drug Reference [32 Related Occurrences]
  - MSDS [3 Related Occurrences]
  - ▶ *List Of* DRUGDEX® Tradename Products
  - ▶ *List Of* MARTINDALE Tradename Products
- **Disease Information**
  - DISEASEDEX(TM) Emergency Medical Abstracts: Rick Bukata MD, Jerry Hoffman MD [1 document]
  - DISEASEDEX(TM) Emergency Medicine Clinical Reviews [8 Related Occurrences]
- **Toxicology Information**
  - POISINDEX(R) MANAGEMENTS [CLONIDINE - Poisindex(R) Management]
  - MEDITEXT MANAGEMENTS [CLONIDINE - TOMES(R) Management]
  - ▶ *List Of* POISINDEX® Products
  - ▶ *IDENTIDEX® System* Tablet & Capsule Identification
- **Reproductive Risk**
  - TERIS [CLONIDINE]
  - REPROTOX [CLONIDINE]
  - SHEPARD'S [CLONIDINE]

MicroMedex

REPROTOX

CLONIDINE

Clonidine (Catapres) is used as an antihypertensive agent. It acts in the vasomotor centers of the brain to inhibit peripheral sympathetic activity and lower blood pressure. Clonidine has also been studied as an epidural or intrathecal analgesic (1,2,23-27). Clonidine is sometimes used in combination with methadone or other opiates by patients who abuse drugs (28).

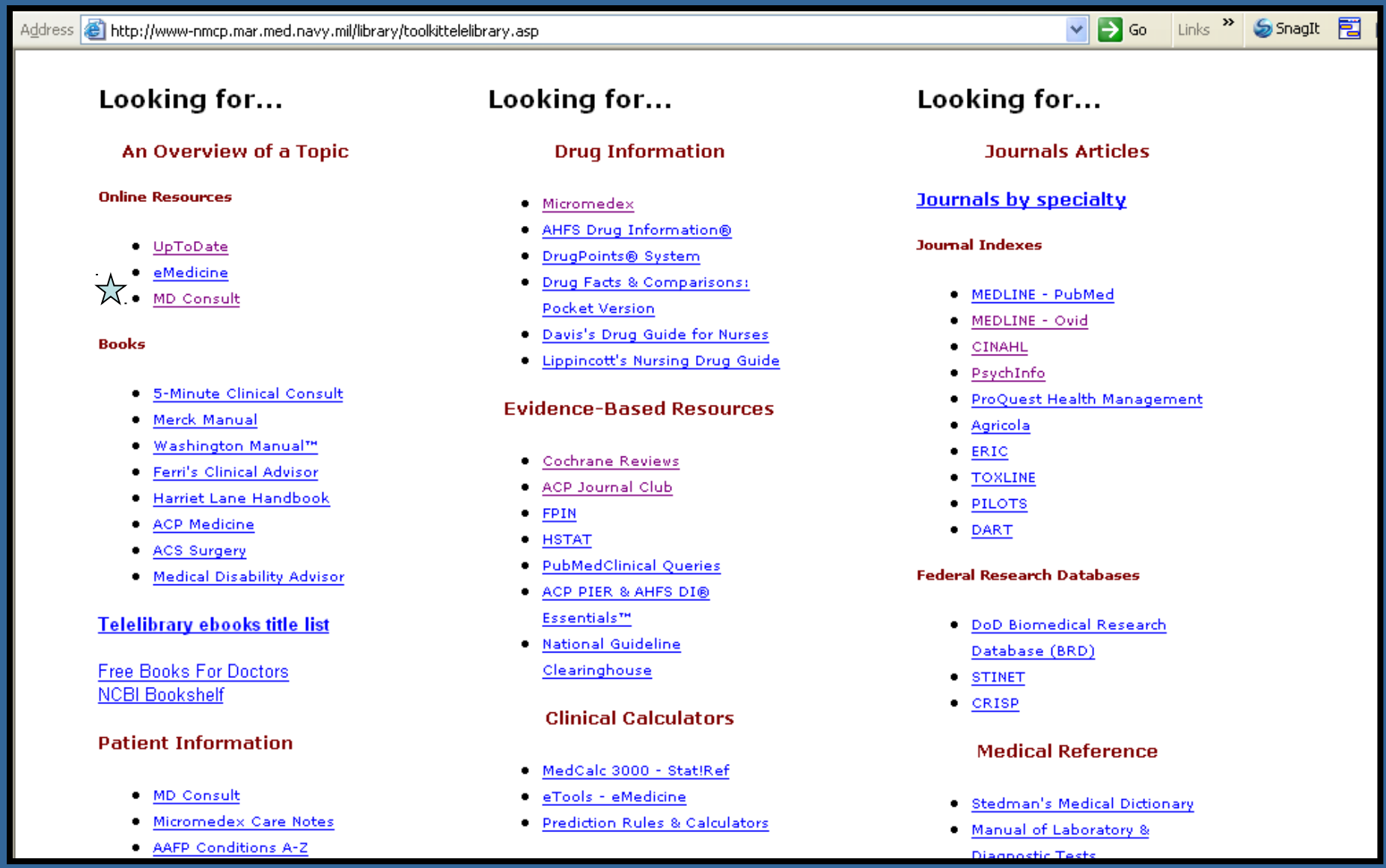
Clonidine crosses the placenta in humans with cord blood drug levels at term similar to maternal blood levels (3). The available teratogenicity studies in animals suggest that clonidine does not induce malformations or embryotoxicity at doses that are not toxic to the mother (4). Doses of clonidine that are lethal to some pregnant mice impair fetal growth and produce cleft palate (5). Experiments in pregnant ewes have demonstrated that high doses of intravenous clonidine increase intraamniotic pressure, and decrease uterine blood flow and fetal oxygenation (6,7). Clonidine has also been shown to inhibit breathing movements in the fetal lamb, and concern has been expressed that this inhibition may impair fetal lung development (8).

In contrast, however, clinical studies involving more than 200 women who received clonidine in the treatment of hypertension during the second and third trimesters of pregnancy have not indicated that this agent was associated with significant adverse effects in exposed offspring (9-12). Transient neonatal hypertension has been reported among the infants of women treated with clonidine late in pregnancy (29), but this complication appears to be uncommon (9).

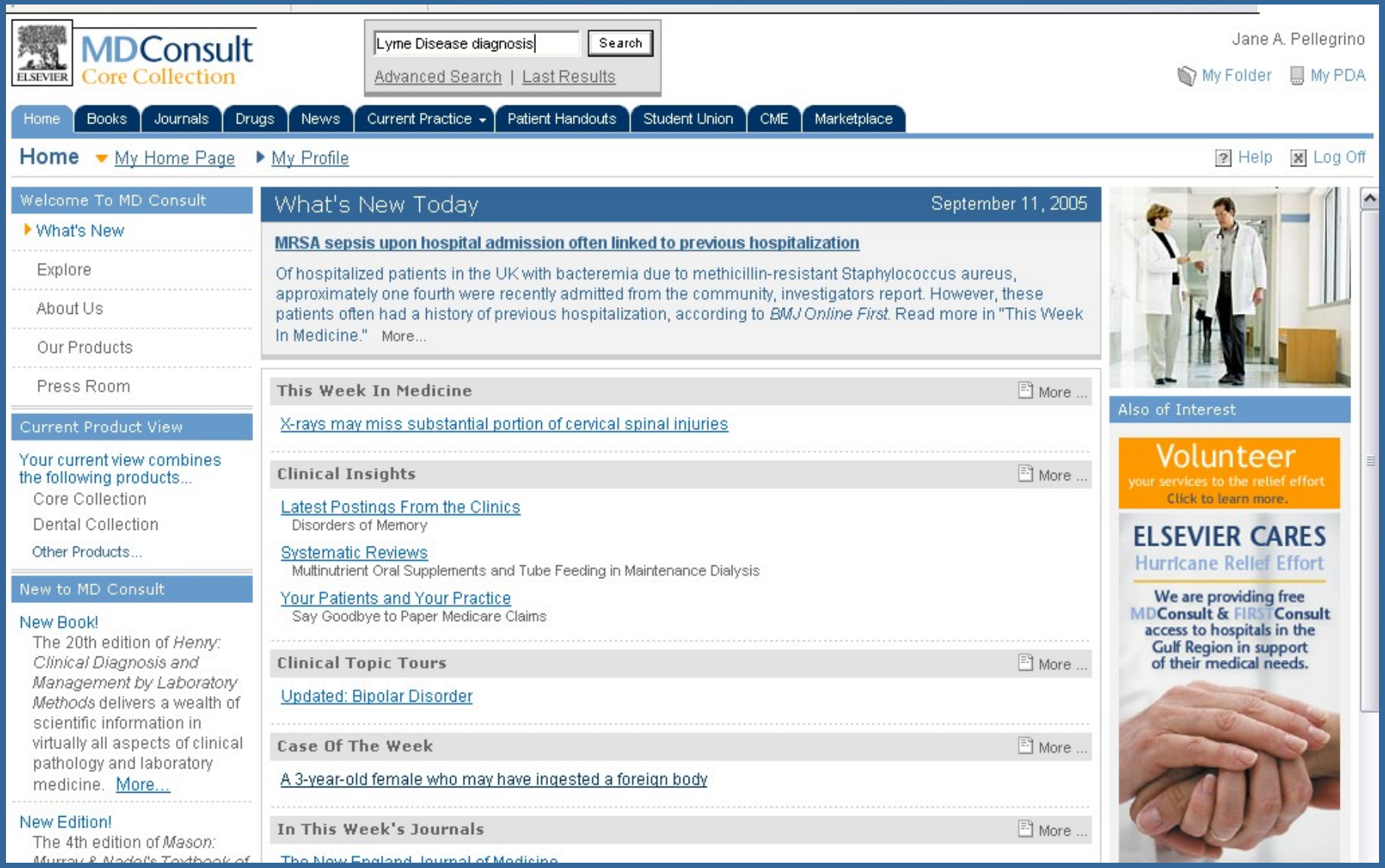
Question #4 –
Looking for an overview?
Try eBooks: MD Consult or Stat!Ref

What are the diagnostic criteria for Lyme disease?

Choose MD Consult or a specific ebook



MD Consult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The 20th edition of Henry: Clinical Diagnosis and Management by Laboratory Methods delivers a wealth of scientific information in virtually all aspects of clinical pathology and laboratory medicine. More...
New Edition!
The 4th edition of Mason:
What's New Today
September 11, 2005
MRSA sepsis upon hospital admission often linked to previous hospitalization
Of hospitalized patients in the UK with bacteremia due to methicillin-resistant Staphylococcus aureus, approximately one fourth were recently admitted from the community, investigators report. However, these patients often had a history of previous hospitalization, according to BMJ Online First. Read more in "This Week In Medicine." More...
This Week In Medicine
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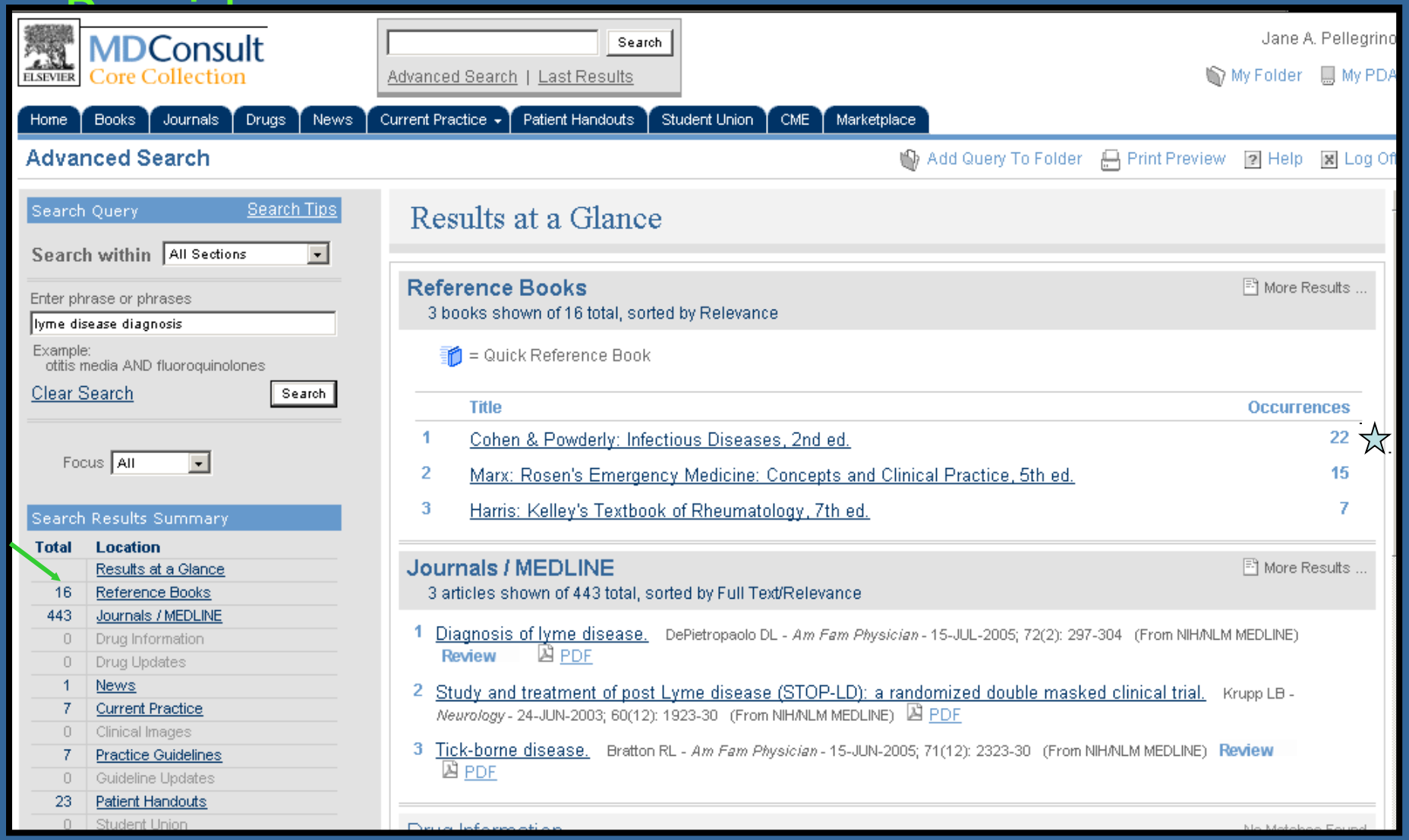

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Women's Health Topics
Lyme Disease
What is Lyme disease?
Lyme disease is an infection caused by the bite of an infected tick. The tick is so small that you may not notice the tick or its bite. Many ticks do not carry Lyme disease, Even if a tick is infected, it may not transfer the disease to you. An infected tick that is attached for under 36 hours is less likely to transmit infection. For these reasons, most tick bites do not cause Lyme disease.
The disease often begins as a rash. If you don't get treatment, the infection can cause serious nerve or heart problems as well as a disabling type of arthritis (pain and swelling in one or more joints caused by inflammation).
How does it occur?
Bacteria called Borrelia burgdorferi cause Lyme disease. The disease is spread to human beings by the bite of a tiny tick infected with the bacteria. These ticks are found in vegetation and on animals in woodlands, grasslands, and marshlands. Wild birds, mice, raccoons, and deer, as well as cats, dogs, horses, and cows, can carry the infected ticks. Ticks may climb on humans from leaf litter and low-lying vegetation in wooded, brushy, or grassy areas. Ticks cannot jump or fly.
People usually become infected during the summer, when they are more likely to be exposed to ticks. Hikers, campers, hunters, and people living in wooded or rural areas have a higher risk for Lyme disease.
This infection has been found on all continents except Antarctica. In the U.S. the infection is more common in the northern states.
What are the symptoms?
Lyme disease is hard to diagnose because its symptoms can vary greatly from person to person. The first symptoms may not even be noticed.

Question #5 –
Looking for a guideline?

Try ACP PIER at Stat!Ref or the National Guideline Clearinghouse

Should healthy patients over 65 years of age receive pneumococcal vaccine and does immunization reduce hospitalization for pneumonia?

Evidence-based resource

Looking for...

An Overview of a Topic

Online Resources

- UpToDate
- eMedicine
- MD Consult

Books

- 5-Minute Clinical Consult
- Merck Manual
- Washington Manual™
- Ferri's Clinical Advisor
- Harriet Lane Handbook
- ACP Medicine
- ACS Surgery
- Medical Disability Advisor

Telelibrary ebooks title list

Free Books For Doctors
NCBI Bookshelf

Patient Information

- MD Consult
- Micromedex Care Notes
- AAFP Conditions A-Z

Looking for...

Drug Information

- Micromedex
- AHFS Drug Information®
- DrugPoints® System
- Drug Facts & Comparisons: Pocket Version
- Davis's Drug Guide for Nurses
- Lippincott's Nursing Drug Guide

Evidence-Based Resources

- Cochrane Reviews
- ACP Journal Club
- FPIN
- HSTAT
- PubMedClinical Queries
- ACP PIER & AHFS DI® Essentials™
- National Guideline Clearinghouse

Clinical Calculators

- MedCalc 3000 - Stat!Ref
- eTools - eMedicine
- Prediction Rules & Calculators

Looking for...

Journals Articles

Journals by specialty

Journal Indexes

- MEDLINE - PubMed
- MEDLINE - Ovid
- CINAHL
- PsychInfo
- ProQuest Health Management
- Agricola
- ERIC
- TOXLINE
- PILOTS
- DART

Federal Research Databases

- DoD Biomedical Research Database (BRD)
- STINET
- CRISP

Medical Reference

- Stedman's Medical Dictionary
- Manual of Laboratory & Diagnostic Tests

EBM Resources

ACP PIER from Stat!Ref

ACP PIER

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pneumococcal vaccines
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Patient Information [1]
Point of Care [3]
ACP's PIER: Physicians' Information and Education Resource [3]
Titles By Discipline [22]
Additional Resources
National Guideline Clearinghouse [4 +]
PubMed [1924]
Related Concepts
pneumococcal vaccine
streptococcus pneumoniae vaccine
Search All Related Concepts
3 documents in 1 title with 10 matches for pneumococcal vaccines [Search Details]
Auto Precision: Exact phrase (OADJ)
1. Other Complications of Sickle Cell Anemia and Their Management
ACP's PIER: The Physicians' Information and Education Resource » Diseases » "S"
Diseases » Sickle Cell Anemia » TABLES - ADDITIONAL
2. Community Acquired Pneumonia
ACP's PIER: The Physicians' Information and Education Resource » Diseases » "C"
Diseases
... using influenza and pneumococcal vaccines in all patients who are at high risk of developing pneumonia and its complications. ...
3. Otitis Media with Effusion
ACP's PIER: The Physicians' Information and Education Resource » Diseases » "O"
Diseases
... [1] Straetemans M, Sanders EA, Veenhoven RH, Schilder AG, Damoiseaux RA, Zielhuis GA. Pneumococcal vaccines for preventing otitis media. Cochrane Database Syst Rev. 2002;(2):CD001480. Review. ...
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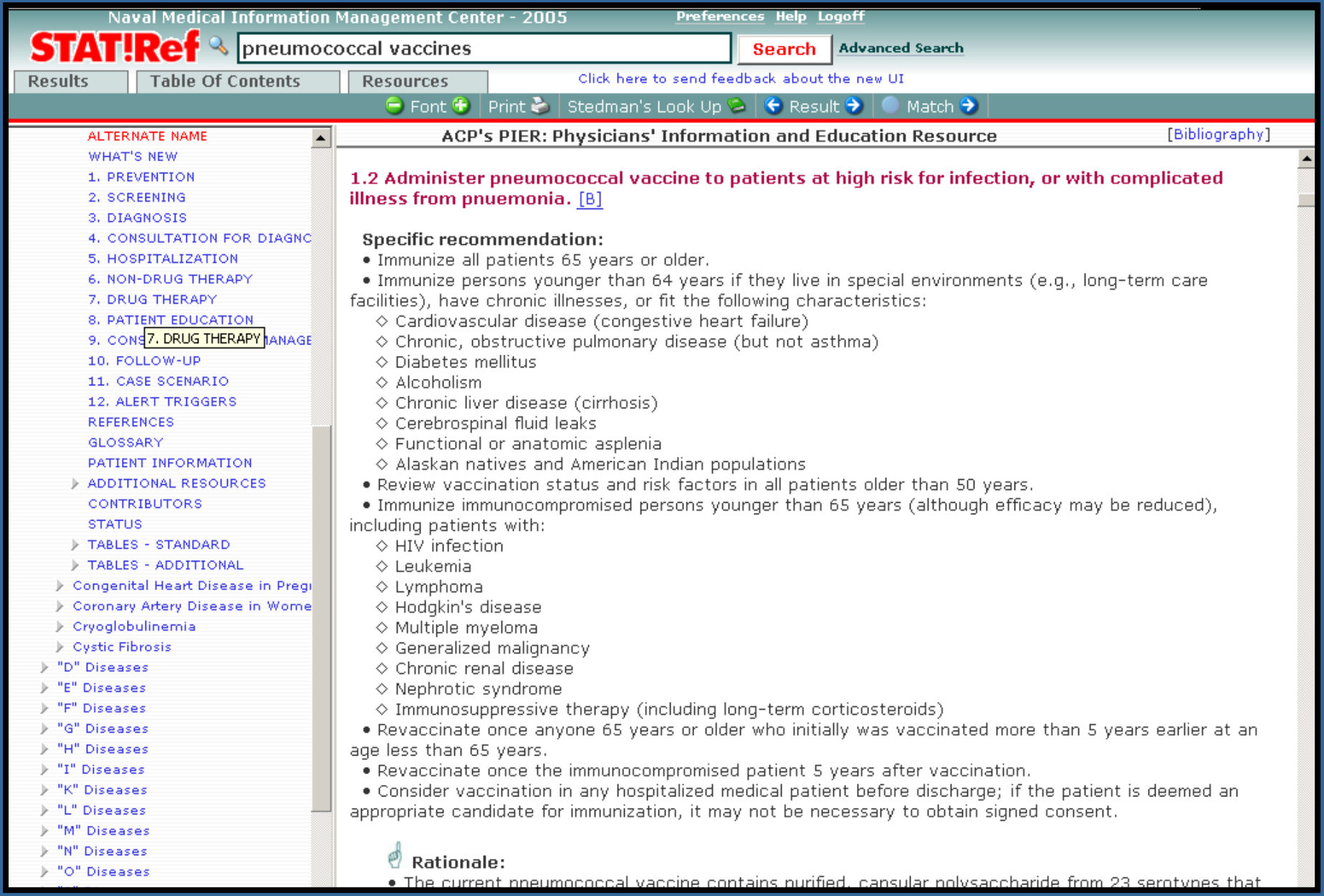
EBM Resources

ACP PIER from Stat!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Coronary Artery Disease in Wome
Cryoglobulinemia
Cystic Fibrosis
"D" Diseases
"E" Diseases
"F" Diseases
"G" Diseases
"H" Diseases
"I" Diseases
"K" Diseases
"L" Diseases
"M" Diseases
"N" Diseases
"O" Diseases
ACP's PIER: Physicians' Information and Education Resource
[Bibliography]
1.2 Administer pneumococcal vaccine to patients at high risk for infection, or with complicated illness from pnuemonia. [B]
Specific recommendation:
• Immunize all patients 65 years or older.
• Immunize persons younger than 64 years if they live in special environments (e.g., long-term care facilities), have chronic illnesses, or fit the following characteristics:
◇ Cardiovascular disease (congestive heart failure)
◇ Chronic, obstructive pulmonary disease (but not asthma)
◇ Diabetes mellitus
◇ Alcoholism
◇ Chronic liver disease (cirrhosis)
◇ Cerebrospinal fluid leaks
◇ Functional or anatomic asplenia
◇ Alaskan natives and American Indian populations
• Review vaccination status and risk factors in all patients older than 50 years.
• Immunize immunocompromised persons younger than 65 years (although efficacy may be reduced), including patients with:
◇ HIV infection
◇ Leukemia
◇ Lymphoma
◇ Hodgkin's disease
◇ Multiple myeloma
◇ Generalized malignancy
◇ Chronic renal disease
◇ Nephrotic syndrome
◇ Immunosuppressive therapy (including long-term corticosteroids)
• Revaccinate once anyone 65 years or older who initially was vaccinated more than 5 years earlier at an age less than 65 years.
• Revaccinate once the immunocompromised patient 5 years after vaccination.
• Consider vaccination in any hospitalized medical patient before discharge; if the patient is deemed an appropriate candidate for immunization, it may not be necessary to obtain signed consent.
Rationale:
• The current pneumococcal vaccine contains purified, capsular polysaccharide from 23 serotypes that

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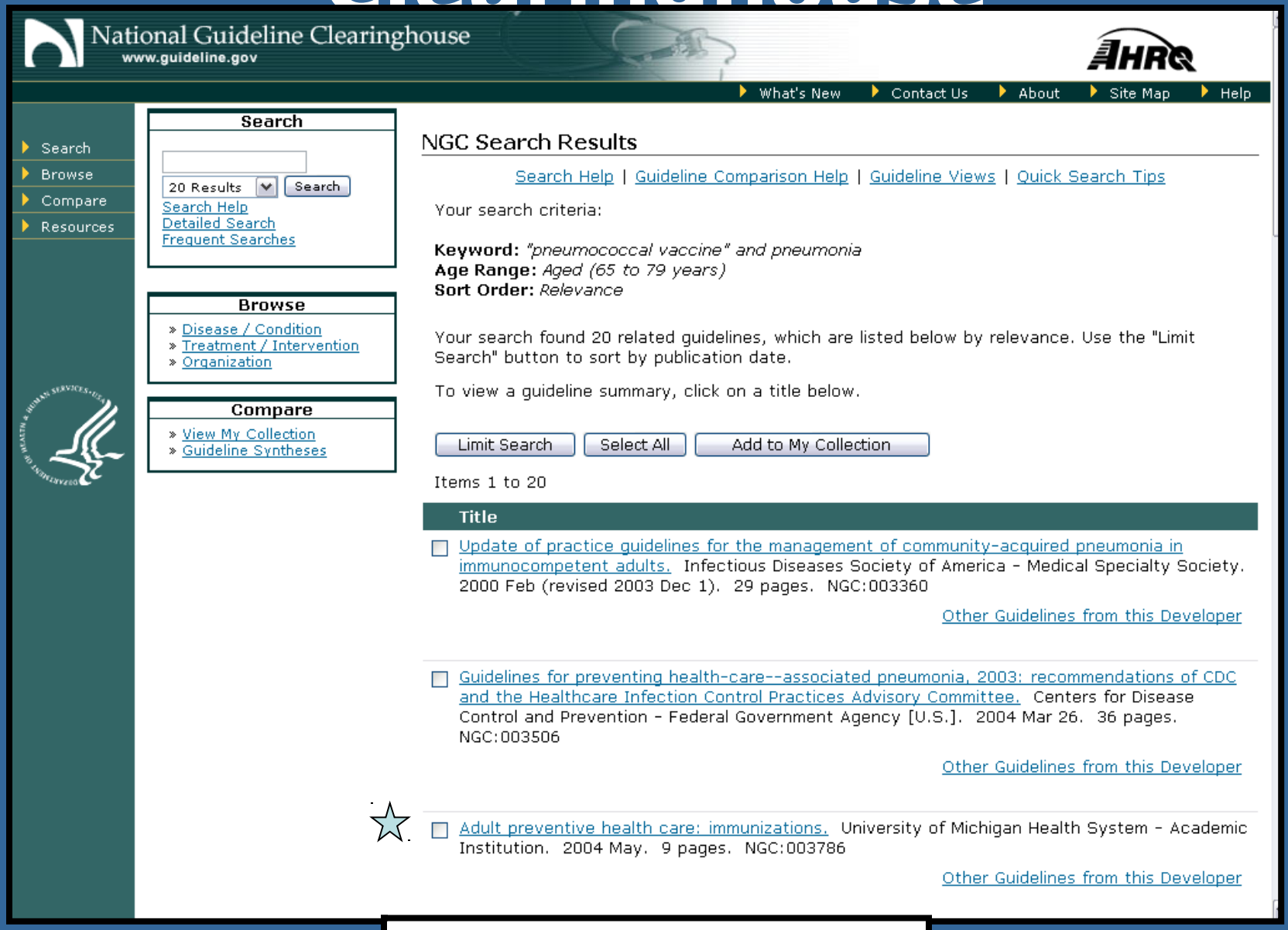
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Vaccine Recommendations

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): The following key points summarize the content of the guideline. Refer to the original guideline document for additional information.

The levels of evidence [A-D] are defined at the end of the "Major Recommendations" field.

Influenza Vaccines

Initial dose: Inactivated (injectable)

- **Adults** >50 years old [*B*]
- Persons with chronic illnesses (e.g., cardiovascular, pulmonary, renal, metabolic, sickle cell disease, immunosuppression/human immunodeficiency virus [HIV])
- Residents of long-term care facilities [*B*]
- Women who are pregnant
- Health care workers, including home care and long-term care workers [*A*]
- Household contacts and out-of-house caregivers of children <6 months
- Others who can transmit influenza to a high risk population

Initial dose: Live attenuated (intranasal)

- For non-pregnant healthy persons <50 years old in priority populations, live attenuated vaccine may be used as an alternative to inactivated vaccine.

  (Non-priority healthy persons <50 years old may receive either vaccine if supply allows.)

Revaccinate annually

- Persons eligible under criteria for initial immunization

Pneumococcal Polysaccharide Vaccine

Initial dose:

- All **adults** >65 years old [*B*]
- Residents of nursing home and long-term care facilities
- Persons with chronic illness (e.g., cardiovascular, pulmonary [except asthma], diabetes, kidney or liver

Answer to the first part of the question

Search the journal literature to answer the second part of the question

Should healthy patients over 65 years of age receive pneumococcal vaccine and does immunization reduce hospitalization for pneumonia?

When the textbooks or guidelines do not answer the specific question

Use PubMed with LinkOut or CINAHL to look for journal articles

Journal Searching

~ beyond Google

- MEDLINE (complete MEDLINE indexes 6000 journals)
  - PubMed
  - Ovid Online
- Ovid Online (MEDLINE, PsycINFO)
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Using MEDLINE or CINAHL to find articles on a specific

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- eMedicine
- MD Consult

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Evidence-Based Resources

- Cochrane Reviews
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- DART

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- CRISP

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- Stedman's Medical Dictionary
- Manual of Laboratory & Diagnostic Tests

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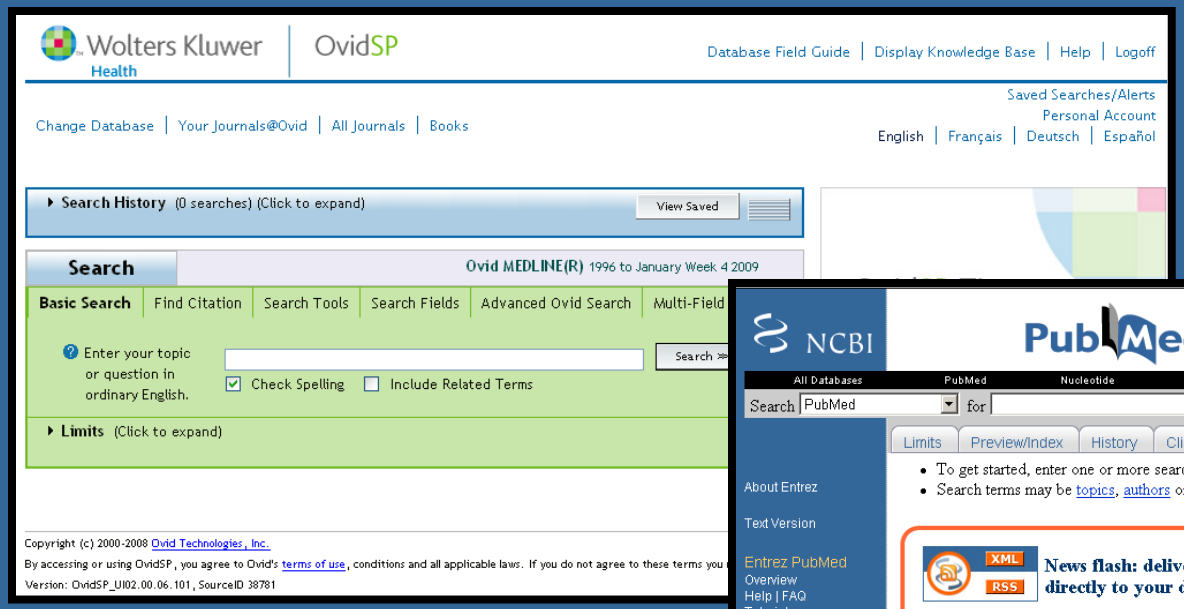
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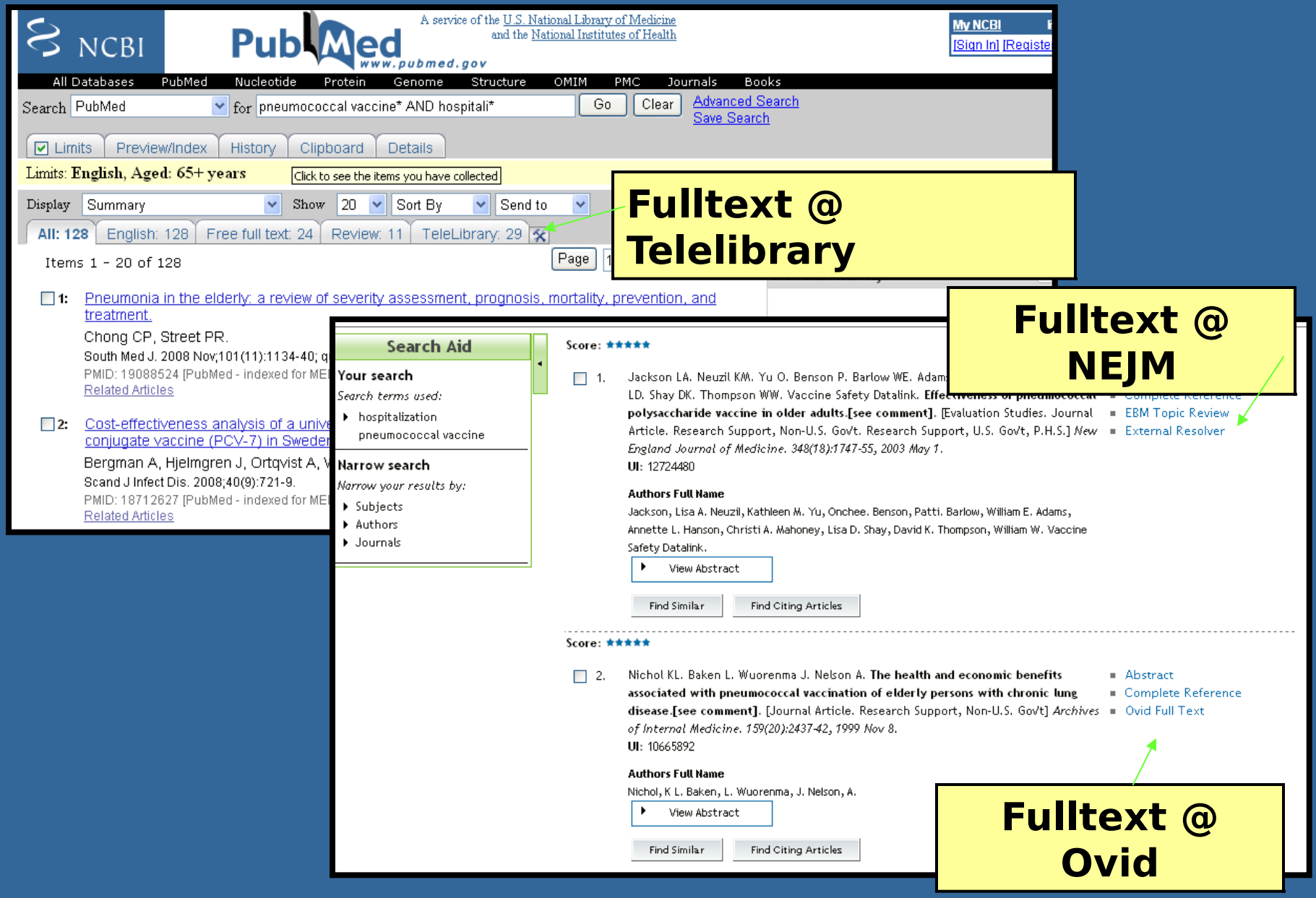
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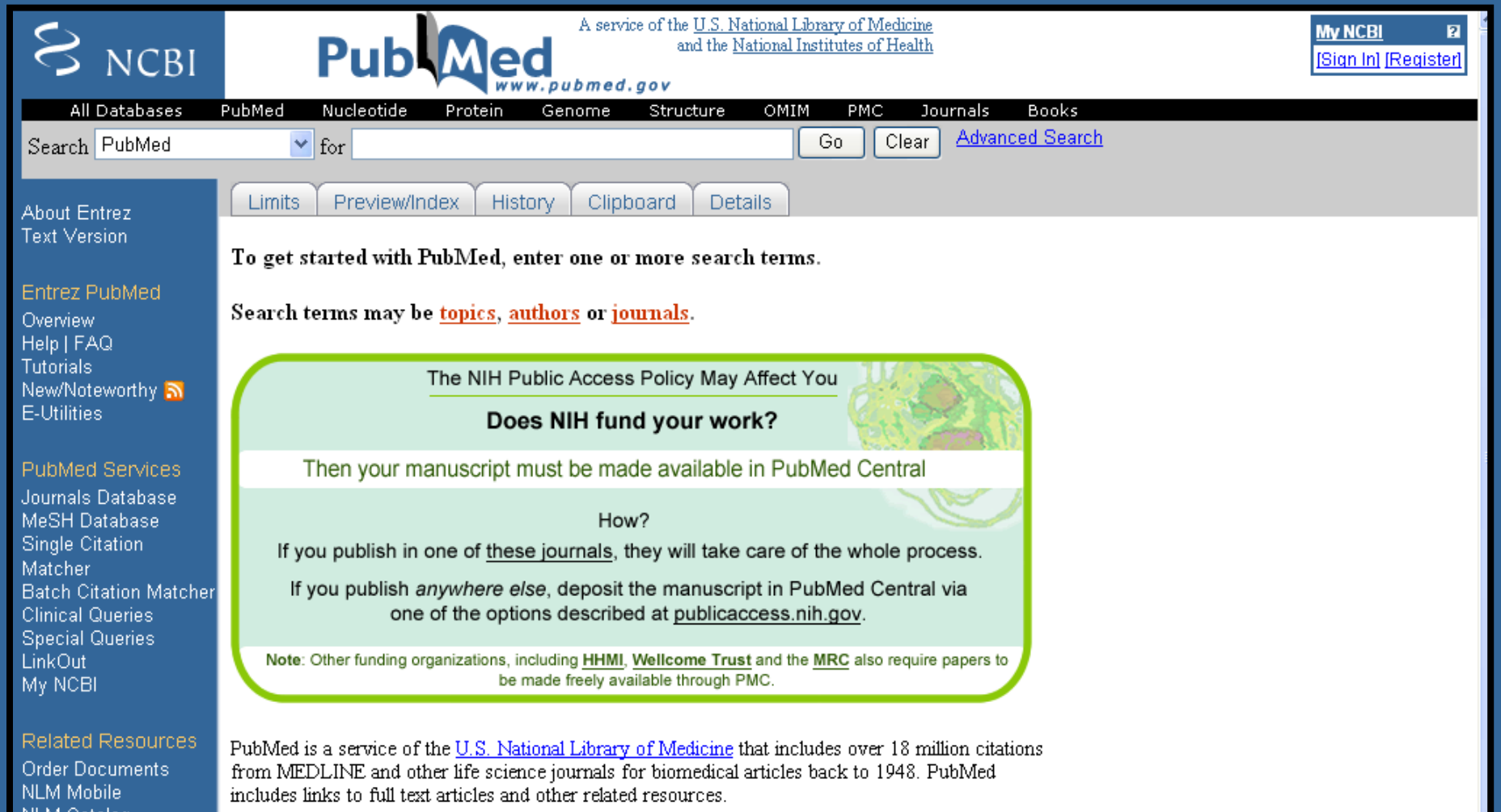
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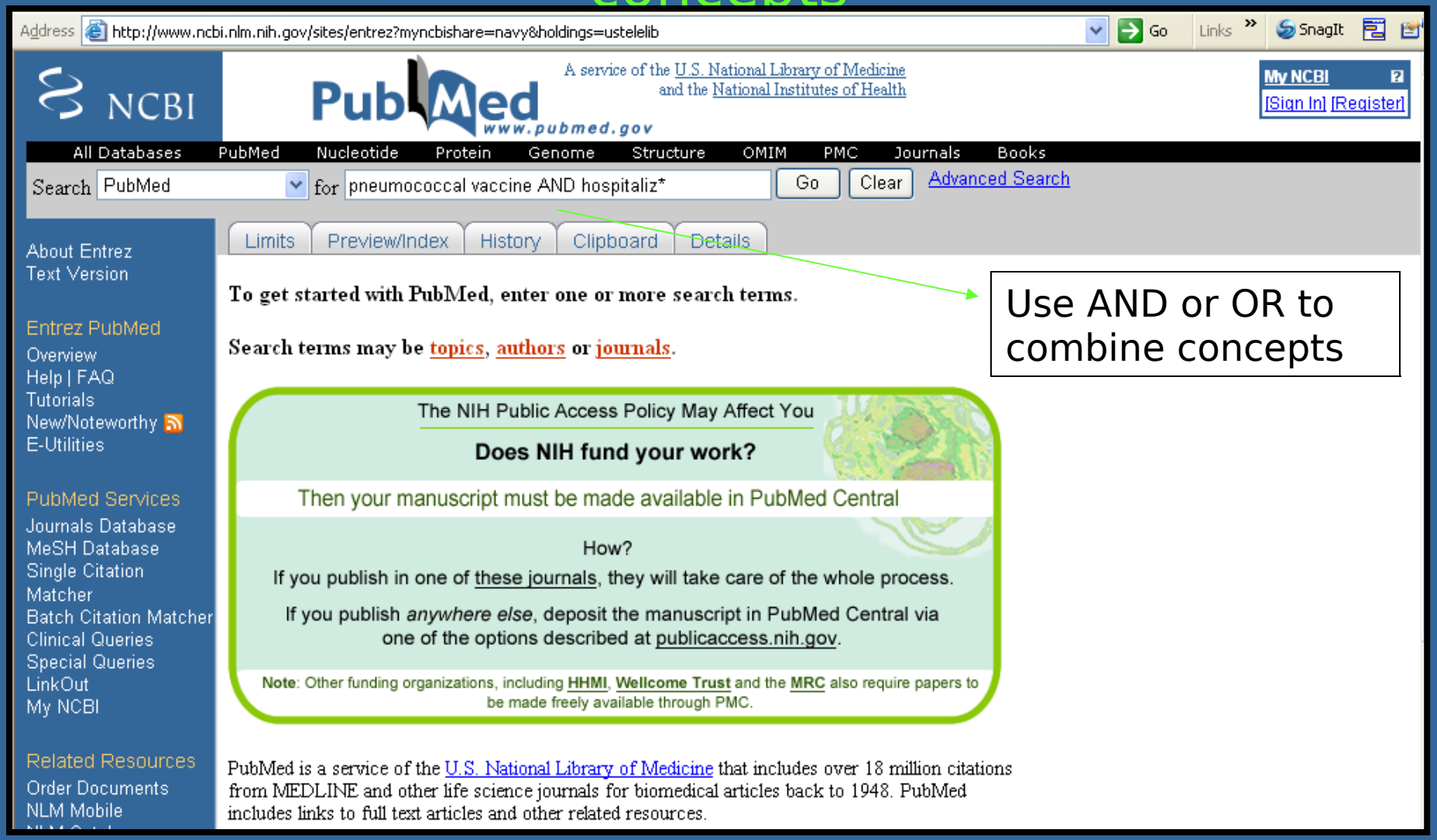
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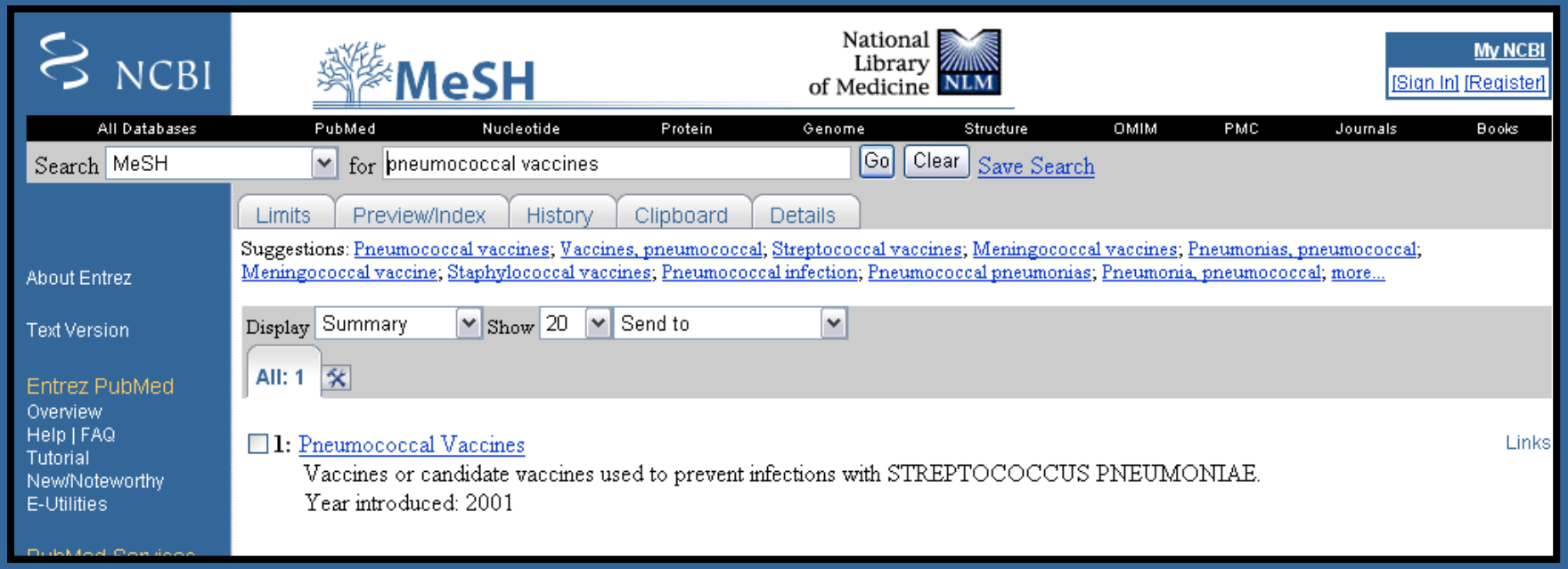
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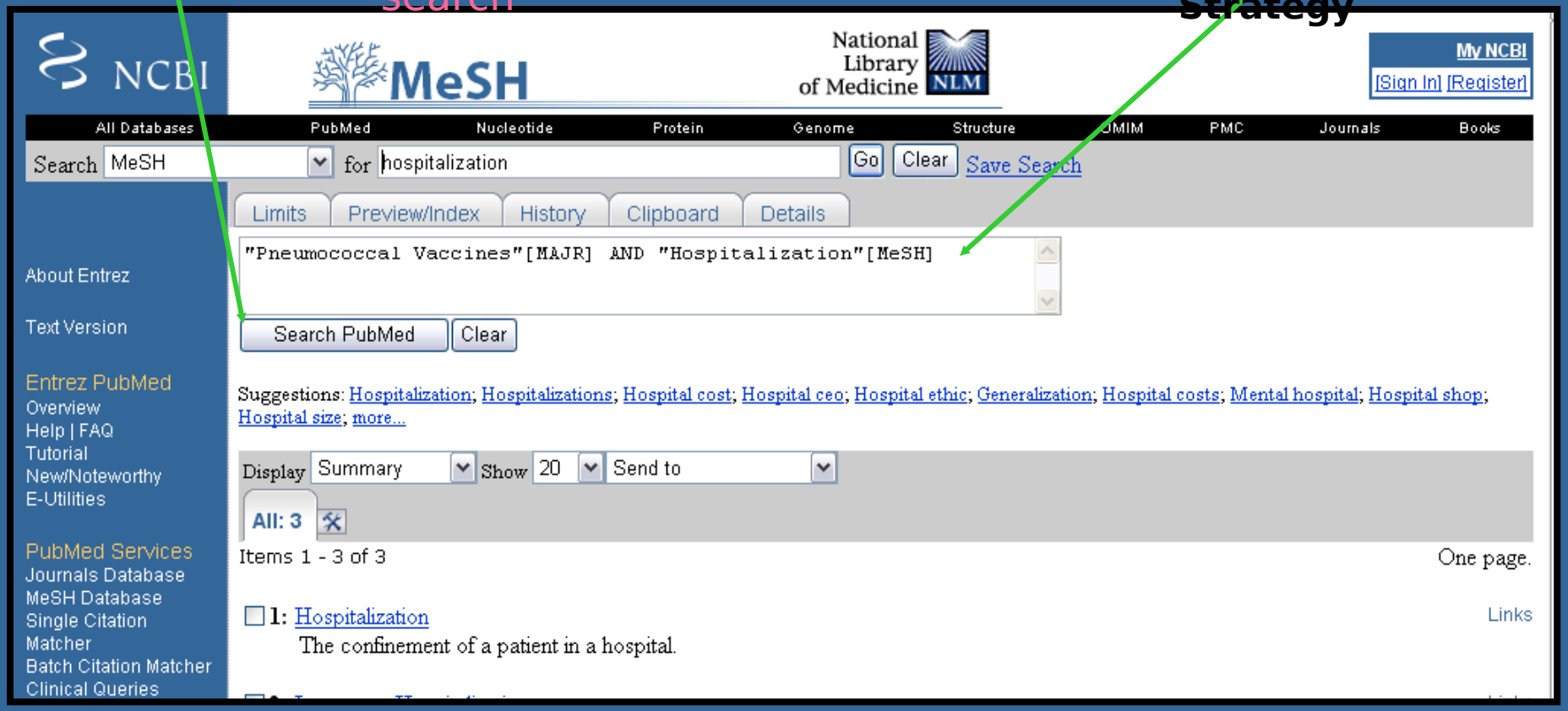

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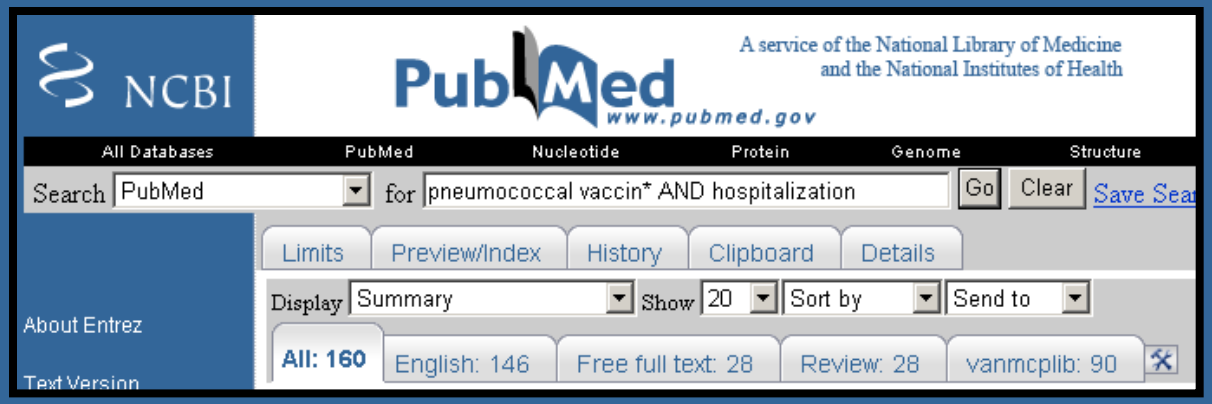

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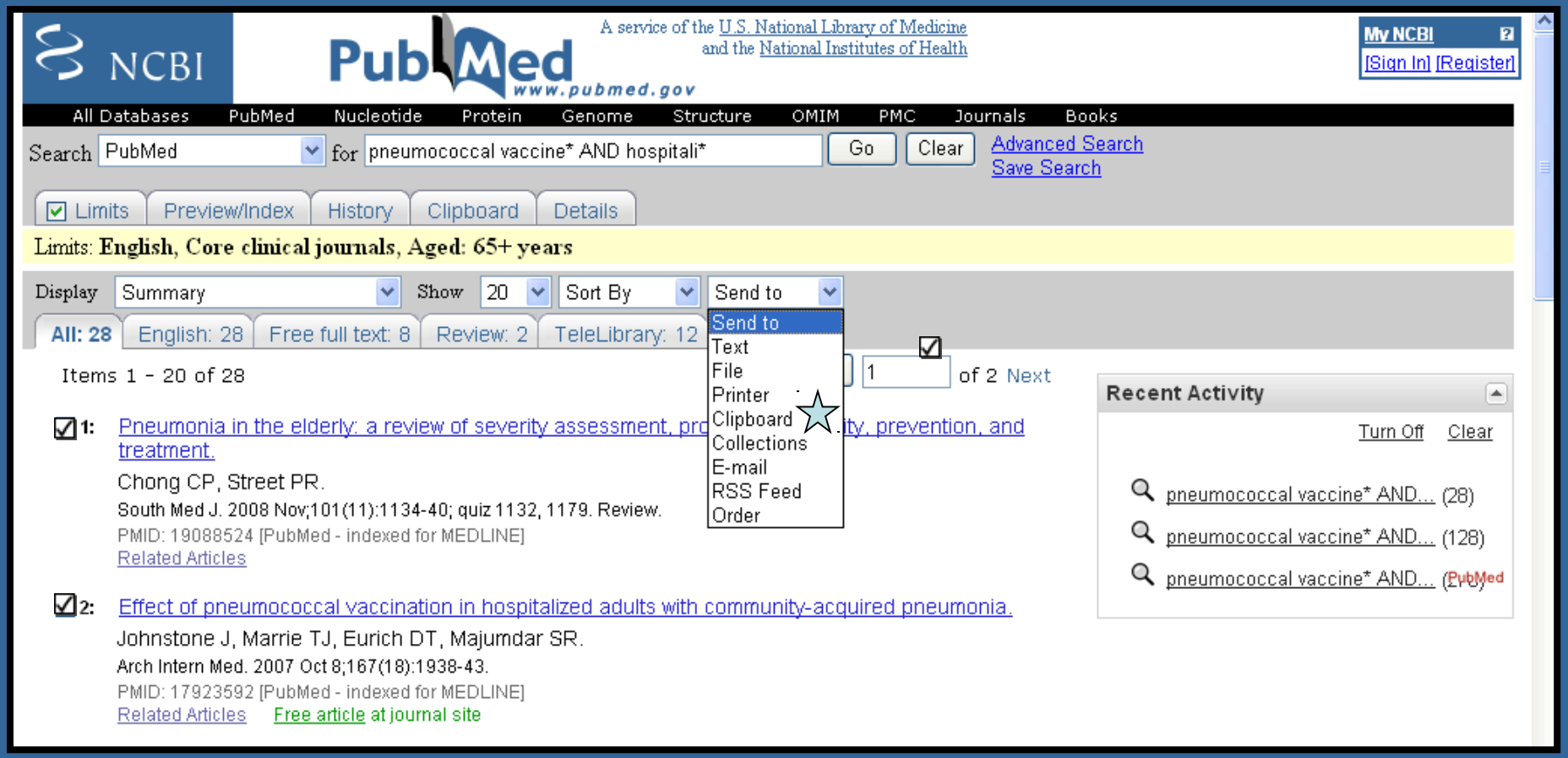

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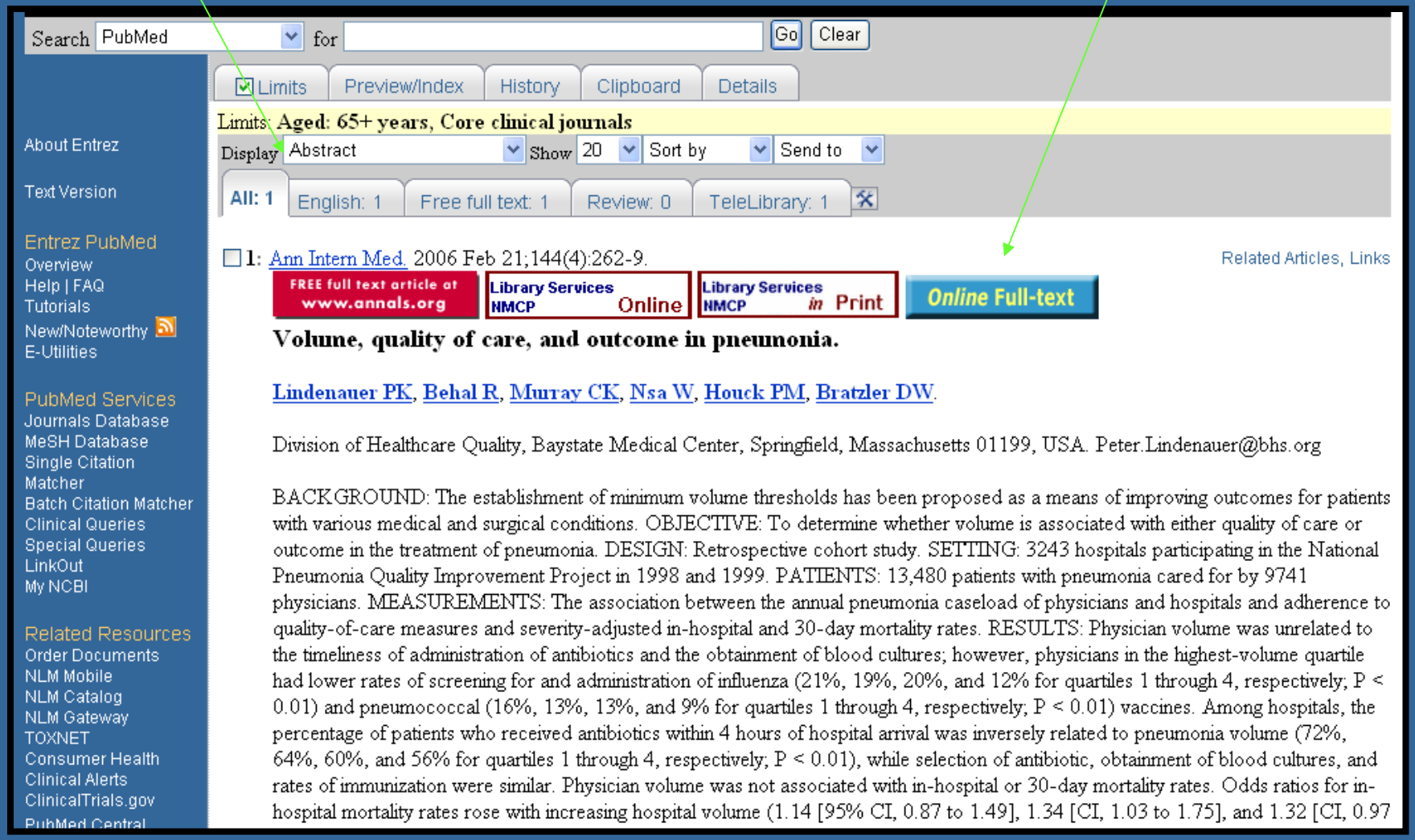
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Lindenauer PK, Behal R, Murray CK, Nsa W, Houck PM, Bratzler DW.
Division of Healthcare Quality, Baystate Medical Center, Springfield, Massachusetts 01199, USA. Peter.Lindenauer@bhs.org
BACKGROUND: The establishment of minimum volume thresholds has been proposed as a means of improving outcomes for patients with various medical and surgical conditions. OBJECTIVE: To determine whether volume is associated with either quality of care or outcome in the treatment of pneumonia. DESIGN: Retrospective cohort study. SETTING: 3243 hospitals participating in the National Pneumonia Quality Improvement Project in 1998 and 1999. PATIENTS: 13,480 patients with pneumonia cared for by 9741 physicians. MEASUREMENTS: The association between the annual pneumonia caseload of physicians and hospitals and adherence to quality-of-care measures and severity-adjusted in-hospital and 30-day mortality rates. RESULTS: Physician volume was unrelated to the timeliness of administration of antibiotics and the obtainment of blood cultures; however, physicians in the highest-volume quartile had lower rates of screening for and administration of influenza (21%, 19%, 20%, and 12% for quartiles 1 through 4, respectively; P < 0.01) and pneumococcal (16%, 13%, 13%, and 9% for quartiles 1 through 4, respectively; P < 0.01) vaccines. Among hospitals, the percentage of patients who received antibiotics within 4 hours of hospital arrival was inversely related to pneumonia volume (72%, 64%, 60%, and 56% for quartiles 1 through 4, respectively; P < 0.01), while selection of antibiotic, obtainment of blood cultures, and rates of immunization were similar. Physician volume was not associated with in-hospital or 30-day mortality rates. Odds ratios for in-hospital mortality rates rose with increasing hospital volume (1.14 [95% CI, 0.87 to 1.49], 1.34 [CI, 1.03 to 1.75], and 1.32 [CI, 0.97

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Peter K Lindenauer; Raj Behal; Cynthia K Murray; Wato Nsa; et al
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Volume, Quality of Care, and Outcome in Pneumonia

Peter K. Lindenauer, MD, MSc; Raj Behal, MD, MPH; Cynthia K. Murray, PhD; Wato Nsa, MD, PhD; Peter M. Houck, MD; and Dale W. Bratzler, DO, MPH

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Objective: To determine whether volume is associated with either quality of care or outcome in the treatment of pneumonia.

Design: Retrospective cohort study.

Setting: 3243 hospitals participating in the National Pneumonia Quality Improvement Project in 1998 and 1999.

Patients: 13 480 patients with pneumonia cared for by 9741 physicians.

Measurements: The association between the annual pneumonia caseload of physicians and hospitals and adherence to quality-of-care measures and severity-adjusted in-hospital and 30-day mortality rates.

Results: Physician volume was unrelated to the timeliness of administration of the first dose of antibiotics (median, 8 hours for quartiles 1 through 4; $P > 0.01$) and blood cultures (median, 4 hours for quartiles 1 through 4, respectively; $P < 0.01$) vaccines. Among hospitals, the percentage of patients who received antibiotics within 4 hours of hospital arrival was inversely related to pneumonia volume (72%, 64%, 60%, and 56% for quartiles 1 through 4, respectively; $P < 0.01$), while selection of antibiotic, obtainment of blood cultures, and rates of immunization were similar. Physician volume was not associated with in-hospital or 30-day mortality rates. Odds ratios for in-hospital mortality rates rose with increasing hospital volume (1.14 [95% CI, 0.87 to 1.49], 1.34 [CI, 1.03 to 1.75], and 1.32 [CI, 0.97 to 1.80] for quartiles 2 to 4, respectively); however, odds ratios for 30-day mortality rates were similar.

Limitations: This study was limited to Medicare beneficiaries 65 years of age and older. Ascertainment of some measures of the quality of care and severity of illness depended on the documentation practices of the physician.

Conclusion: Among both physicians and hospitals, higher pneumonia volume is associated with reduced adherence to selected guideline recommendations and no measurable improvement in

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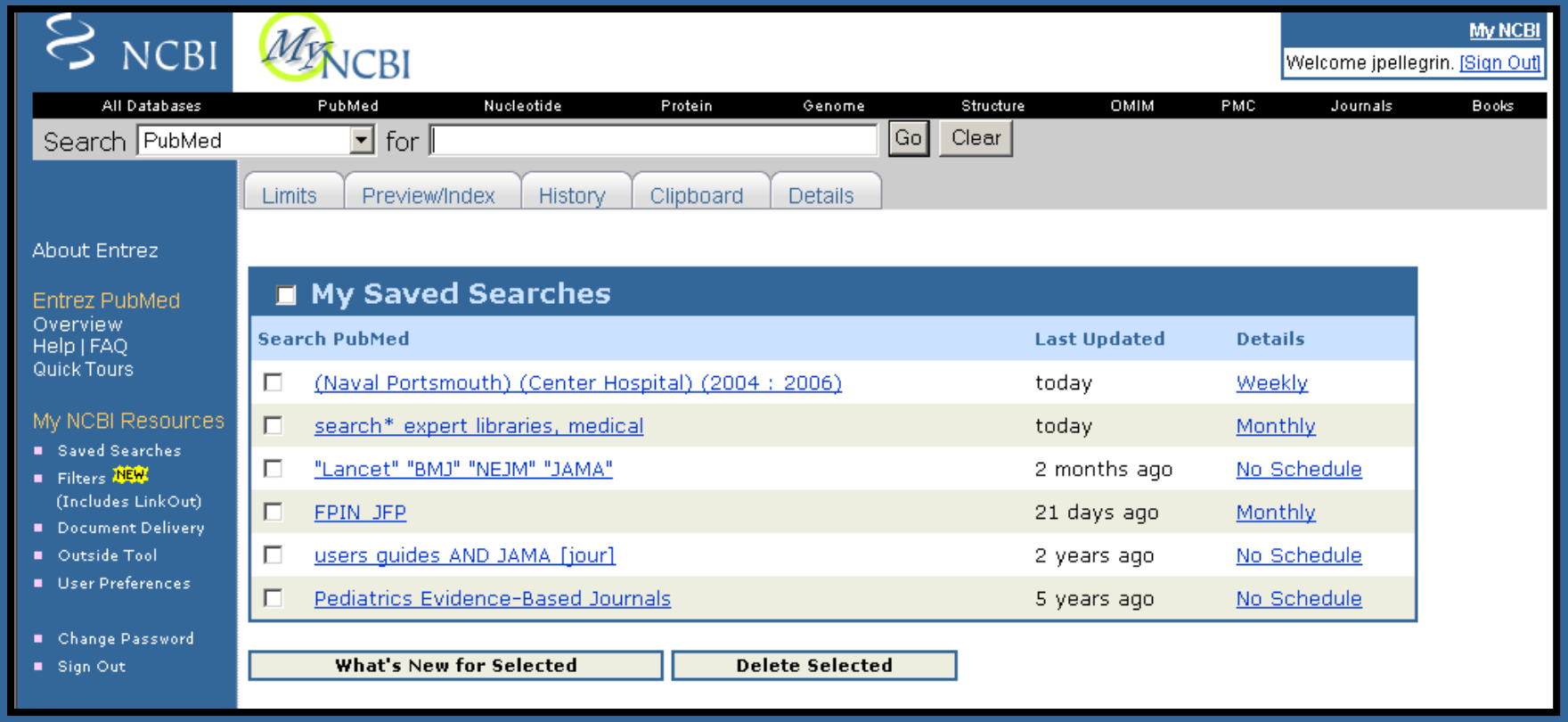

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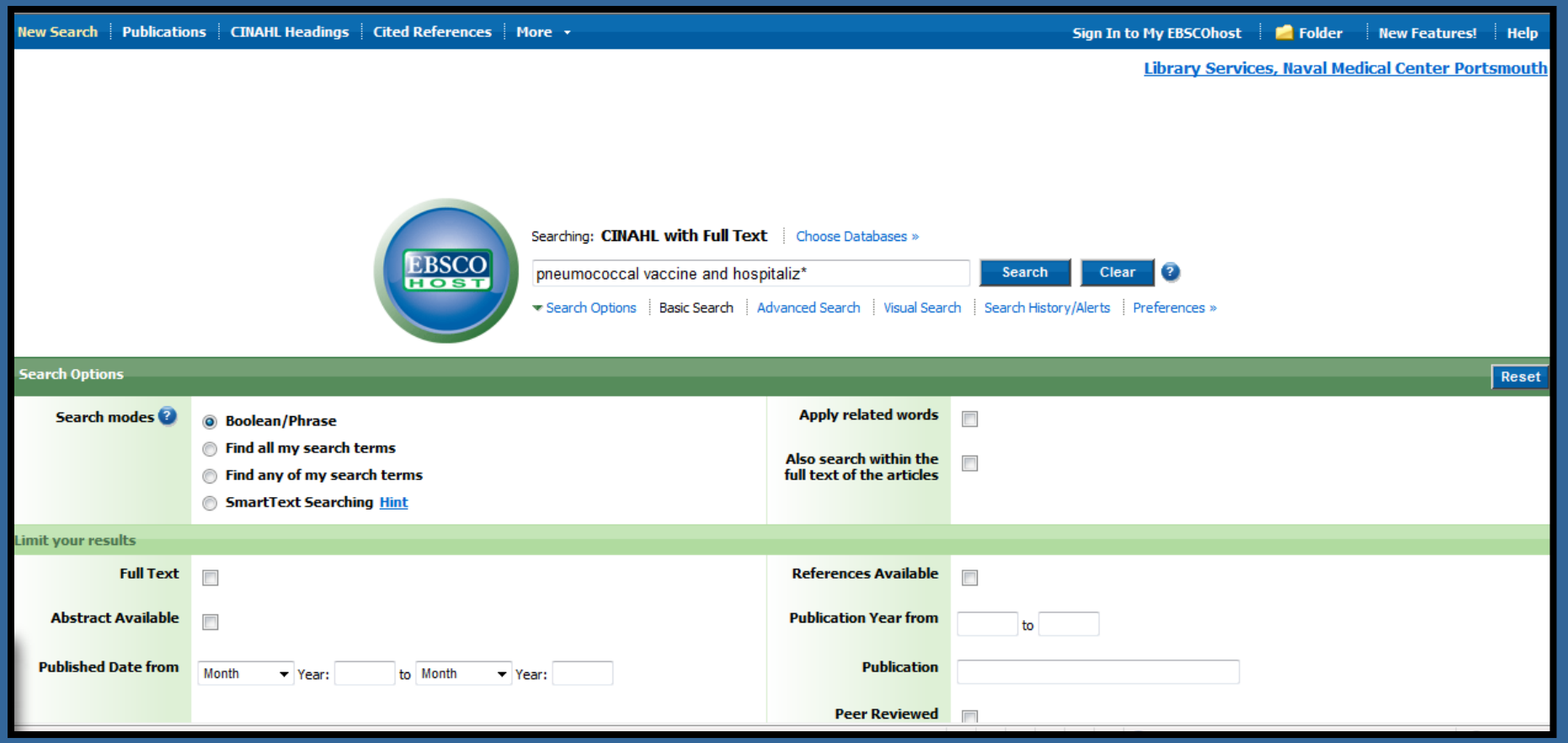

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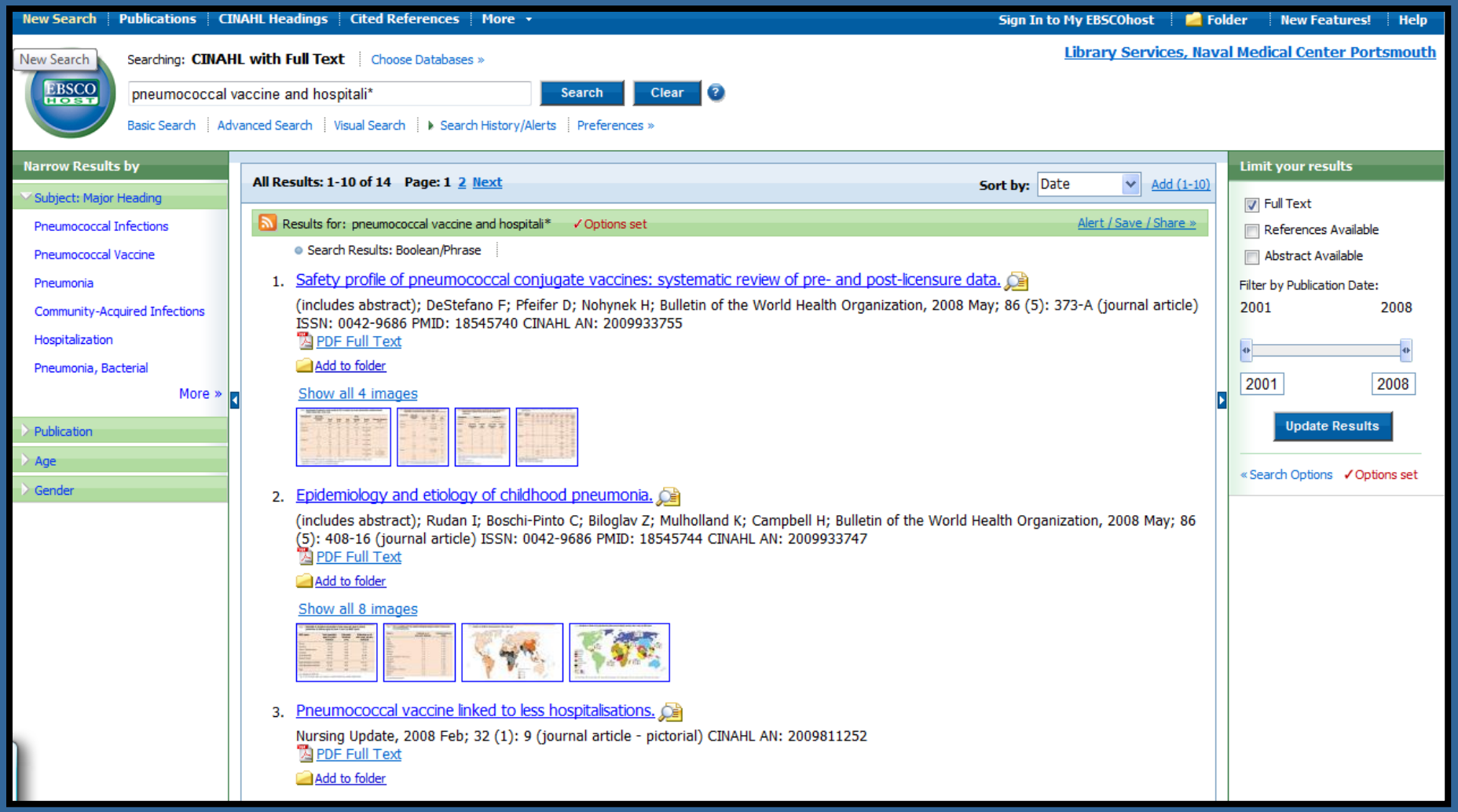
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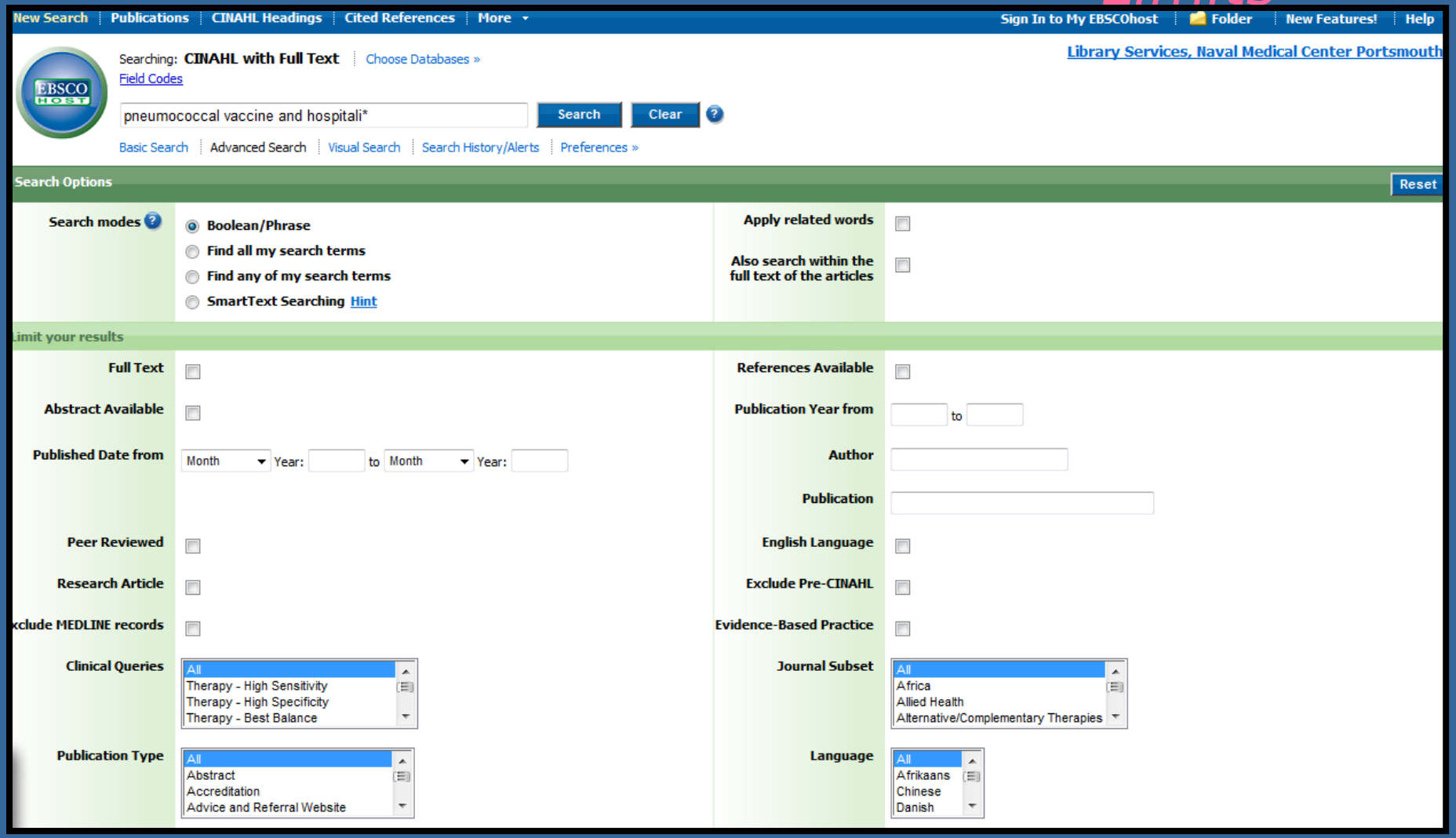

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PEKKA HONKANEN[1], ESA LÄÄRÄ[2], REIJO PYHÄLÄ[3], SIRKKA-LIISA KIVELÄ[4] & PIRJO HELENA MÄKELÄ[3]

From the [1]Department of General Practice and Public Health Science, University of Oulu, Kemi Health Centre, Kemi, [2]Department of Mathematical Sciences, University of Oulu, [3]National Public Health Institute, Helsinki, [4]Department of Family Medicine, University of Turku, Turku University Hospital and Satakunta Central Hospital, Turku, Finland

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